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GUY'S HOSPITAL GAZETTE

PASSIM

About Towne

One of Guy's most celebrated possessions is the Towne Collection of wax models displayed in the Gordon Museum. The collection of over 50 anatomical dissections and 400 specimens of skin diseases is unique; its accuracy and detail have yet to be equalled and the techniques of Towne are still shrouded in mystery 87 years after his death.

It is not surprising that the recent reports about the dispersal of part of the collection have prompted immediate protests from Guy's men all over the world. The report originated from ideas that parts of the collection which are somewhat duplicated might be put on permanent loan to other teaching hospitals. This would facilitate plans for modernizing the Gordon Museum. It has now been decided by the Museum Committee that the Towne collection should remain permanently in its entirety at Guy's.

There are plans, however, to re-organize the display of the collection, which has remained in its present uninspired layout too long. The exhibition of skin diseases presents a monotonous spectacle of row upon row of pots shouldering each other off the shelves. Their faded labels of an old nomenclature serve to amuse the initiated and confuse the student. Each one of these pots contains a masterpiece, and individually removed from their present bus-queue-like display their value is enhanced enormously. To display these specimens in a way deserving to Towne's work they should be separated, mounted in new cases and labelled in modern terminology.

Another neglected possession of the Museum is the extraordinary Lan-Qua paintings which adorn the walls of the lecture room. There is little known about the origins of this collection, which is part of a series of paintings, the remainder of which hang in the Library of the Medical School of Yale University. In the near future the collection at Guy's is to be restored from its present pitiable condition by the Victoria and Albert Museum.

The extended opening hours of the Wills Library, although occasionally not running smoothly, has greatly benefited its users. A similar system for the Gordon Museum, which could stay open later, supervised by assistant student curators, would be of great value. Another small alteration which would enhance the facilities of the

Wills Library and Gordon Museum is the opening of the existing passage between the two. The resulting unit of inter-communicating library and museum, open in realistic hours when students can best use them (i.e. after 6 p.m.) would take better advantage of the present facilities.

The Gordon Museum is one of the few good remaining examples of Victorian iron and glass architecture, and a gem amongst Guy's patchwork of buildings. Any future plans for alteration of the Museum should be based on the preservation of its present fine architecture while modernizing the presentation of its exhibits, particularly the jungle on the ground floor.

Alchemy and the Modern Medical Dream

"It's good news week!
Someone's found a way to give
The rotting dead a will to live,
Go on and never die!"

Although the logic of this verse from a recent pop song could most certainly be questioned, the general idea and sentiment behind it, despite the veneer of snide modern cynicism, is as universal and as old as man.

In the Middle Ages, when plague wiped out whole populations of people, Medicine often did no more than lend truth to Petrarch's famous skit: "Life is short enough, but the physicians with their art, know to their amusement, how to make it still shorter." In the face of this impotence the alchemists of the day escaped into dreams and spent their lives searching for the imaginary Philosopher's stone that would change baser metals into gold and with it the Panacea or Elixir of Youth which would enable them to live for ever in the enjoyment of their riches.

With the advent of modern science, times have indeed changed; in 1949, mercury was converted into gold in a nuclear reactor and one dream had come true (though at a cost that would have been considered a pyrrhic victory by most alchemists). Furthermore, today, due to modern hygiene and medicine, the average man's life-span in Britain is nearly three times what it was in the Middle Ages. Humanity can already be justly amazed at its own power. But what effects have these advances had on the hopes of today's scientists? What is, in fact, the modern medical dream?

On listening to medical scientists speculating on the discoveries that they hope to see within their lifetimes, one feels that success and understanding have brought with them modesty. Gone are the wild suggestions of immortality but left are more concrete objectives; the solution to the problems of neoplasia, the mastery of viruses, and the

prevention of auto-immunity, etc. But although these may appear modest goals, they lie at the heart of the biological mechanism and if pushed to state his hopes for the science in future generations, any man of imagination would find it difficult to deny that we seem to be moving towards the alchemists' other dream.

Already in Cambridge, Dr. Robert Edwards has succeeded in culturing mature human ova with a view to studying early embryology. In the future, perhaps, the cruder notions of organ-banks could be superseded by discovering the basis of the embryological differentiating mechanisms and by means of a "neo-organogeny", new organs could be bred from any cell that contained the full genetic complement of the zygote.

Whether or not the alchemist, indulging in his simple reverie, was, by chance, also predicting the progress of human science is impossible to say, but our generation has indeed some cause to wonder if the medicine of our distant descendants will be aimed at immortality.

GUY'S DIARY

JANUARY

Exhibition :			Burns.
13th	Th.	1.00	Clinical Lecture. Dr. HARDWICK. "Diabetic Coma".
17th	M.	1.00	Clinical Lecture. Dr. HALL. "Some Problems of Out-patient Anaesthesia-Medical and Mediocolegal".
20th	Th.	1.00	Clinical Lecture. Mr. WILLMORE.
20th	Th.	5.00	Neurosurgical Round: Mr. MURRAY FALCONER, in Clinical Theatre.
22nd	Sa.	10.00	Clinico-Pathological Meeting in Clinical Theatre.

NOTICES

The Biennial Dinner

The year's Biennial Dinner will be held at the Connaught Rooms on Friday, October 7th, 1966. Further details will be announced later.

The Rose Ball

The Rose Ball will be held at the Savoy Hotel on Friday, 21st January. Tickets can be obtained from the Appointments Bureau.

Wills Library

There will be an exhibition of 15th—19th century books in the Nag's Head Yard Library on Wednesday, January 5th, from 12 noon to 5.30 p.m.

ACCIDENT PRONENESS

John C. Crisp

Case History

Gary E., aged four years, was admitted to Diplock from Casualty with bilateral periorbital oedema and a temperature of 100° F. A deep infected laceration discharging pus was found on his forehead. This wound was sustained a week earlier, while Gary was playing near his home. He was treated with penicillin and the wound was cleaned and dressed. After four days his temperature had returned to normal and the oedema around his eyes had almost completely dispersed. He was discharged after a week in hospital.

While in hospital, Gary's father expressed concern about Gary—"he keeps falling over and hitting his head." Mrs. E. agreed with this. On examination, Gary was found to have numerous scars on his scalp and forehead, and also on his arms and legs. The central nervous system was found to be normal.

Gary is a well-built and vigorous four-year-old who lives with his parents, elder brother and sister and younger sister in a new L.C.C. maisonette, in South East London. The flat is not roomy enough for a lively child to play in, and neither is there a suitable playground nearby. Indeed the immediate surroundings of the flat far from providing a safe environment for a child, puts many dangerous obstacles in his path. Amongst these hazards are rough concrete steps with no suitable banister, sharp square concrete posts and roads busy with traffic.

Gary spends a great deal of his time with his elder brother, and his mother is preoccupied with the housework, the eighteen-month-old baby, and with the work she goes out to do in the evenings. The father does not discourage the children from fighting and rough play.

It was thought that Gary was a normal but very lively child who was frustrated when kept in the small flat, but at risk when allowed to play by himself outside. It was decided to press for an early entry into day school.

Review of the Literature

Accident Proneness implies that certain individuals are more liable to have repeated accidents than others, even given the same degree of risk.

Children are naturally accident prone due to physical and intellectual immaturity. The elderly are naturally prone to accidents through infirmity. Others may be accident prone due to physical, emotional or psychological characteristics or defects. Accident proneness is also the main feature of a definite personality type.

The concept of accident proneness is originally derived from the study of industrial accidents by Greenwood and Woods in 1919[1]. They found that eighty per cent of the accidents occurred to only twenty per cent of the workers. They also found that many of this twenty per cent were susceptible to repeated accidents. Many subsequent studies have endorsed these findings.

Dunbar, F. in 1943,[2] was engaged in a survey of patients in hospital suffering from peptic ulceration; she took as her control group patients who she supposed to be in hospital purely by chance, namely those in fracture wards. However, she found to her surprise that many of these patients had had accidents before and were of a distinct personality type.

She found that they were fit, healthy and usually males between the ages of fifteen and twenty-four years. They had good health records—in marked contrast to the high incidence of repeated accidents amongst them. They were usually of the "happy-go-lucky" type, well liked, talkative and cheerful. They were casual about marriage and employment: they changed wives and jobs easily and frequently. A prominent feature of their personality was impulsiveness; they were men of action rather than deliberation. They concentrated on immediate pleasure rather than long term goals, and they liked adventure, excitement and sports. They were always in a hurry even with plenty of time to spare.

Dunbar also found that many of them had conflicts with authority, e.g. with parents, schoolmasters, employers and marital partners. In younger life they may steal and play truant, but these tendencies disappear later in life. Dunbar likened the accident prone personality to that of the juvenile delinquent; while one breaks laws, the other breaks bones. The accident prone personality-type always has a good deal of pent-up aggression and resentment.

Accident prone persons are neither clumsy, badly co-ordinated or slow in reacting, nor will examination of their central nervous systems reveal any abnormality. But Dunbar found that in eighty to ninety per cent of those studied, something was worrying them immediately prior to the accident. This was often something which they had just done and which they knew was not quite correct. For example, disobedience of parents or independent behaviour. After the accident these patients often expressed feelings of guilt—the accident had "served them right." "It serves me right; mother said there wasn't enough time to go out before supper."

This is what is described as the accident prone personality. Other workers have endeavoured to show the effect on accident statistics of transferring the accident repeaters to other, safe occupations. Rawson, A. J.,[3] in 1944, did a survey of fourteen hundred drivers in two large transport companies in the U.S.A. He found that when the twenty or so per cent of accident repeaters were transferred to non-driving jobs, the accident rate fell to one-fifth of the original level. The transferred drivers still had accidents, but only injured themselves

and not others as well. A survey along similar lines was attempted on Army drivers, but failed to demonstrate that the majority of accidents were sustained by a minority of drivers. But it was then realised that men were allowed to drive in the Army only if they had had no accidents in civilian life. The accident prone had been weeded out from the start.

The actual individuals who make up the accident prone group are always changing. The incidence of accidents amongst the age group fifteen to twenty-five is higher than that in middle age. Normal characteristics of adolescence may cause accident proneness, so most will "grow out" of it. But some members of this group are especially susceptible; and some do not ever grow out of it. Some may be accident prone due to emotional causes that resolves with time or treatment, and so leave the accident prone group.

But proneness is a comprehensive term and should include all those prone to accidents through whatever cause whether it be physical, emotional, intellectual or psychological.

Children and Accidents

All children are naturally accident prone because they have not yet reached their full capabilities either physically, emotionally or intellectually. And they lack experience. All accident prone children must be investigated thoroughly. Physical examination may reveal defective sight or hearing, or motor inco-ordination. Mentally subnormal children are specially liable to accidents, as are those with sociological or psychological problems.

Given suitable surroundings, the normal child or toddler will play safely and confine his activities to those within his capabilities. Children of all ages can play together in safety if the playground has sensibly constructed amenities. Often the older children will look after the younger ones.

Unfortunately, suitable facilities are seldom to be found in the built-up areas of our towns and cities. Backet and Johnson in 1959[4] described the social patterns of children living in Aberdeen who were involved in road accidents. These families had one or more of the following features:—

(a) Family or Maternal illness. Children from families in which there was serious illness were more liable to have road accidents.

(b) Maternal preoccupation. In families where the children had had accidents it was often found that the mother was preoccupied with housework, a younger child, or was out at work.

(c) Lack of room to play. Where there was no appropriate area for play, children were forced on to the streets.

(d) Crowding at home. Children from crowded homes were more liable to accidents.

(The child whose case is described above may be a member of a family "at risk." He has no suitable playground, plays without supervision and his mother is preoccupied with a new flat, a younger sibling and goes out to work in the evening. And they are a family of six living in a small flat.)

But of all the dangers to which a child is exposed, the one which he is least able to deal with is the danger of road traffic. The toddler is especially susceptible to road accidents. The toddler may see a car approaching, but will be unable to appreciate that it will not stop in time to miss him. The toddler thinks of the adult as being all-powerful, and quite capable of stopping a fast-moving car within a few yards if necessary. The toddler is impulsive and will rush out into the road to retrieve a ball without anticipating that a car may be approaching at the same time. The incidence of traffic accidents is highest in the age group four to six years. At this age children are active, impulsive and run rather than walk, but without that grace of movement which implies full control. In the age group seven to nine years, the incidence of road accidents is relatively low—they have gained characteristics which set them apart from toddlers. They are more mature and experienced, and less impulsive. Over the last twenty years these children, in contrast to those in other age groups, show a decline in the number of road deaths—a most encouraging result of the continued programme of education in road safety over those years.

Accidents in the home follow the same pattern. The toddler is much more liable to burns and scalds than the child a few years older. And the same children are "at risk"—those belonging to families living in crowded conditions where the mother is ill or preoccupied.

Psychological factors are also of great importance in the aetiology of accident proneness in children as Frankl[5] emphasises. The newborn infant relies totally on his mother for protection of his body from harm—the baby in a cot may scratch his own face as he does not yet recognise pain as a danger signal. This responsibility gradually passes from mother to child. Factors in a child's environment may interfere with the development of this function of self-preservation and will result in accident proneness—factors which often have an effect on this kind are inadequate mothering and resentment of parents. In the former situation the child may harm himself in an attempt to provoke his parents into showing love and sympathy, and in the latter case, in an effort to spite his parents. Repeated accidents may be symptoms of feelings of guilt or wishes for self-destruction. Accidents, or prolongation of impulsive behaviour in these cases are symptoms of an inner conflict.

Other children may be teased or goaded into emulating the feats of older children—to become "dare-devils". Or they may act recklessly if they think themselves weak, or suppose others to think them weak.

Accidents are always unpleasant experiences. So any child presenting with a history of repeated accidents should be investigated to find out if there is a psychological basis to the problem. Accidents may be the symptom, or the solution of an underlying conflict or the result of a past conflict. Treatment by psychoanalysis is of great value and should be undertaken, for the best effect, before maturity is reached.

Environmental, intellectual and psychological factors leading to accident proneness in children have been described. Defects of physical and mental development are also important. Many of these factors may contribute in any individual case of accident proneness.

Discussion

It has been shown that an understanding of the concept of accident proneness can be used to reduce the number of all kinds of accidents. The fact that it is not used fully is another example of the community's irrational attitude towards the accident problem as a whole. An air-liner crash which kills seventy people may result in the grounding of that model all over the world. However, although one thousand young men are killed every year in motor cycle accidents, mainly through head injuries, the wearing of crash helmets is not compulsory. Similarly, during the long period while legislation was being draughted, hundreds of children were being killed or severely burned when their nightdresses caught fire—which they did very easily. Road accidents "hit the headlines" every bank holiday, but during the rest of the year, while the accident rate continues at the same level, there is little or no publicity. We are constantly bombarded with monthly trade figures and informed of the state of the gold reserves, but why are we not reminded that about twenty road users, many of them children, are killed every day? Neither is the present accident rate a plight which the country can afford financially. One hundred and seventy-five million pounds are spent every year as a result of road accidents alone. The cost of lost man-hours in industry due to accidents is enormous.

Another example of the country's short-sightedness is to be seen in the rebuilding programme. Tall blocks of flats may solve the housing programme but they also deprive children of the "backyard" where they used to play. So children are forced to play in streets and be exposed to the hazards of traffic. When playgrounds are provided they are often dull, flat, lifeless expanses of asphalt. These playgrounds give no scope for the creative or imaginative play essential to a child's development. Recently a bombed site in S.E. London was converted into a playground. An observer of this operation noticed that the only time the local children showed any interest was when the bulldozers had churned the dark earth into an exciting landscape of hills and valleys. Why couldn't the local council have grassed over the ground in this exciting stage? Is it any wonder children love playing and exploring bombed sites and derelict houses; where is the excitement in a flat stretch of asphalt?

Ambitious projects have been undertaken by a few local authorities up and down the country, but they all lack the trained supervision necessary. Many of these schemes have been tremendous successes—a playground should be an integral part of all new housing projects. A little foresight is a small price to pay for the safety of the children who will live in these new flats.

In this and many other fields, research and action can lighten the burden on the country of accidents occurring every day on the road, in the home and on the factory floor. An appreciation of accident proneness is essential if campaigns against accidents are to be successful.

Summary

The case of an accident-prone child has been described, and some of the literature reviewed. It has been shown that "accident repeaters" are found among children, and adults of a certain personality-type. Some aspects of the community's approach to accidents is discussed with particular reference for the need of suitable playgrounds in new housing estates.

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CLUBBING

by Michael Simpson

In 1897, West stated that "Clubbing is one of those phenomena with which we are all so familiar that we appear to know more about it than we really do." Although the condition is widely recognised, no comprehensive theory has yet been put forward to explain it, and gained general acceptance. In 1954, Pyke suggested that "Clubbing" can be an unreliable sign. Sixteen observers were asked to define clubbed fingers, and did so in 14 different ways. The 16 observers (4 senior physicians, 4 medical registrars, 4 surgical registrars, and 4 medical students who had spent 6 months in the wards) were given 12 patients to examine. Their opinion as to whether or not clubbing was present, "varied from unanimity to equal division. When the same observers examined photographs of the same fingers, the results were slightly less decisive".

In the 5th century B.C., Hippocrates described curving of the finger-nails in a case of empyema; and the term "Hippocratic fingers" has been used, although Hippocrates did not describe or recognise the whole phenomenon. The condition was not properly discussed until Pigeaux, in 1832, described clubbed fingers in some detail, mainly in association with pulmonary tuberculosis. Since then, slight variations in the nature of clubbing have earned a welter of terms—watch-glass nails, parrot-beak nails, drumstick fingers, serpent's head or clock pendulum fingers; essential dactylomegaly, hypertrophic acrodactylopathy, and even "acro-elephantiasis ossea sive molle".

Occurrence

Clubbing has been described following a very large variety of conditions. Symmetrical clubbing can be brought about by many types of pulmonary, pleural, and mediastinal disease. In chronic suppurative conditions—bronchiectasis, pulmonary abscess, and empyema—clubbing is common and pronounced. It can also occur in pulmonary tuberculosis, and "in any condition which produces a chronic pneumonitis—pneumoconiosis, atelectasis because of intra-bronchial obstruction", or external compression of the lung by chest deformities—"Pott's disease, rickets, crushing injuries, poliomyelitis, paralysis of the diaphragm or diaphragmatic pleurisy" (Mendlowitz, 1942). It is reported in both congenital and acquired syphilis, actinomycosis, and hydatid cyst of the lung. It is more rare in conditions like congenital cystic disease, chronic passive congestion of the lung, lobar and bronchopneumonia. It is also described in erythremia of high altitudes, disappearing upon return to sea-level. It is said that clubbing due to other causes may become exaggerated on venturing to high altitudes.

Clubbing has also been recognised in a variety of primary pulmonary, bronchial, mediastinal and chest-wall neoplasms—bronchogenic carcinoma, pleural fibroma, carcinoma of the thymus, neurinoma, malignant mediastinal teratoma, lymphosarcoma, sarcoma of the thoracic vertebrae, etc. It may also be seen in Hodgkin's disease involving the lung or mediastinum, and in pulmonary hemangioma; more rarely, it may be seen in pulmonary metastases—in 3 per cent of a series of 34 cases, reported by Aufses and Aufses. The primaries may be cancer of the breast, adrenal, pharynx or parotid, or a sarcoma.

"It is not seen in congenital heart disease, without cyanosis, unless complicated by another disease, such as subacute bacterial endocarditis" (Mendlowitz). It may also occur in chronic congestive heart failure, and aortic aneurysm.

Apart from cardio-pulmonary disease, clubbing has been described in abdominal conditions. It may occur in liver cirrhosis—in hypertrophic or cholangiolytic cirrhosis, and less frequently in toxic cirrhosis and biliary cirrhosis due to bile duct obstruction; and following on amyloidosis involving liver and spleen. Gastro-intestinal conditions, particularly those featuring chronic diarrhoea, may give rise to clubbing—amoebic or bacillary dysentery, intestinal tuberculosis, chronic non-specific ulcerative colitis, regional enteritis, multiple polyposis of the colon, neoplasm or Hodgkin's disease of the small intestine, and, only rarely, carcinoma of the colon. It can occur quite frequently in idiopathic steatorrhoea (sprue). It has been known to follow thyroidectomy for Grave's disease; and a case is reported of clubbing of rapid onset with a Grawitz tumour.

Clubbing may be hereditary, and is a Mendelian dominant trait (Horsfall). Clubbing of the fingers of one hand may be seen, usually due to an aneurysmal dilation of the arch of the aorta, or the innominate or subclavian arteries. Clubbing of only one finger has been described after apparent injury to the median nerve, local trauma to the finger, Boeck's sarcoid, tophaceous gout, and even, as reported by one early French writer, in "felons".

The Nature of Clubbing

Clubbing has been described in the very old, and in infants; its sex distribution naturally depends on that of the underlying diseases. The changes involved may develop slowly over several years; less often, they may occur within a few weeks. The development of clubbing is only very rarely accompanied by subjective sensations. Clubbing of the toes is common, too, but is often harder to recognise, due to the great variation in the shape of normal toes, which may appear clubbed; and to the frequency of deformities caused by shoes, etc. Clubbing of the nose, ears and even the eyelids and malar region have been mentioned.

While the details may differ, several typical changes in clubbing are recognised. (1) When the finger is viewed from the side, there is a flattening of the normally obtuse angle between the proximal part of the nail and the plane of the soft tissue covering its root—Mendlowitz

describes a decrease in the normal angle of $\pm 15^{\circ}$ between the plane of the proximal portion of the nail and the dorsal plane of the bone.

(2) A change in the texture of the tissues becomes evident—the nail plate is more mobile both from side to side and axially.

(3) The distal phalanx is increased in volume—Lovell described an increase of 12 per cent.

(4) The nail itself usually shows a greater curvature in one or both planes. Lovell suggests the following classification of clubbing:—

Slight: Increased fluctuation over nail-bed. Flattening of the dorsal contour.

Moderate: As above—Also appreciable enlargement of pulp; increased curving of the nail.

Marked: Increased fluctuation over nail-bed. Flattening of the dorsal contour, conspicuous enlargement of the pulp. Increased curving of the nail.

Gross: Conspicuous fluctuation over the nail-bed. Flattening of the dorsal contour, with raising of the whole nail-bed region. Conspicuous enlargement of the pulp. Conspicuously increased curving of the nail.

Clubbing is often associated with hypertrophic pulmonary osteo-arthropathy; although Locke found no bone changes in 22 out of 39 cases of clubbing. Where bone changes were present, there was an irregular hypertrophy of the distal half of the terminal phalanges.

Pathology

Studies of the pathology of clubbing have been confusing, due to the difficulty of obtaining suitable specimens, and the tendency of post-mortem changes to mask the changes of clubbing. It seems generally recognised that there is an increased growth of all tissues of the finger-tips; especially the fibrous elastic tissue of the nail-bed. Increase in the fatty connective tissue of the ball of the finger is also described. The experimental pathology, too, has been rather limited; although hypertrophic osteo-arthropathy has been successfully produced by anastomosis of the left and adjacent main pulmonary artery to the left atrium, in dogs. (Mendlowitz and Leslie, 1941).

In clubbed fingers associated with cyanotic congenital heart disease, an increase in the volume of blood in the distal finger segment is described, with a dilation of the skin venous plexuses—although it has been suggested that this may be a reflection of the increased total blood volume, and polycythaemia.

Theories of Pathogenesis

(1) **Atrophic.** 18th century physicians, including Laennec, believed that clubbing was brought about by a sort of differential emaciation, involving wasting of the proximal phalanges.

(2) **Circulatory.** In 1832, Pigeaux ascribed the clubbing he observed, to oedema and increased capillarity of the finger-tip, caused by a "disturbance of the blood" due to changes in respiration or circulation.

(3) **Toxic.**

(a) **Infectious.** At the time when bacteria were beginning to be recognised as the causative agents in some diseases, there was a tendency to blame them for any hitherto inexplicable condition. The tubercle bacillus was for a time accused of causing clubbing, though this was soon shown not to be the case.

(b) **Toxaemic.** Clubbing was later believed to be due to circulating toxins acting on peripheral capillaries. In 1901, Béclère suggested "a hypothetical systemic toxaemia resulting from the inability of the lungs to remove from the blood toxic substances produced normally by the tissues. This could be brought about by a pulmonary-systemic shunt, or by impaired pulmonary function".

This suggestion was rejected by Mendlowitz—"It soon became evident that this theory was inadequate to explain even ordinary varieties of clubbing, much less hereditary or unilateral forms."

Despite this, as will be seen, Beclérè's 1901 hypothesis very closely resembles that put forward by Hall in 1959.

(4) **Mechanical.** Clubbing was said to be due to capillary stasis, caused by back pressure. Yet this failed to explain why patients with heart-failure seldom showed clubbing. Later, it was suggested that circulating toxins were produced by changes in systemic or local circulation, which affected "trophic" nerves, directly causing clubbing in some fashion. Here, there was no explanation of why, of the whole cardio-vascular system, only the capillaries of the finger-tips were affected.

(5) **Anoxic.** According to this theory, local anoxia or arterial anoxaemia was said to lead to capillary stasis. Yet clubbing is not noted in severe anaemia, methaemoglobinaemia, or Raynaud's Disease; and several investigations failed to show any degree of capillary stasis.

(6) **Reflex.** More recently (Holling, Brodey and Boland, 1961; Flavell, 1956), the hypothesis has been put forward that clubbing is a reflex vascular response; that the increased blood flow is maintained by a reflex with its afferent path via the vagus nerves, and its efferent path possibly in the spinal sympathetic outflow. Wilson (1952) confirmed that an increased blood-flow through clubbed fingers existed, but maintained that it was "not due to the action of vasodilator nerves".

(7) **Bizarre.** Caron blamed the absorption of toxins from the digestive tract. Holthusen accused the endocrine glands—and the pituitary, thyroid, parathyroid, and even the gonads have been involved at various times. Other hypotheses have proposed nerve lesions; lymph stasis; excessive cooling of the finger-tips; and even the liberation of nitrogen in the periosteum.

Present Views

Mendlowitz (1938) described a calorimetric method of measuring heat elimination from the finger-tip. He found that the maximum heat elimination and thence the blood-flow, through the distal

phalanges of clubbed fingers following lung or congenital heart disease, was usually increased. The blood-flow through the unilaterally clubbed finger-tip was increased or decreased. Other writers have described increased vascularity in the terminal phalanx, and a dilation of the venous plexuses.

So there is an increased blood flow in the terminal phalanx of clubbed fingers. Increased blood-flow is not recognised as leading to proliferation of fibrous tissue, except in association with chronic inflammation, and there is no evidence of a local inflammatory reaction in clubbing.

The site of maximum deposition of fibrous tissue in clubbing is the nail-bed, where Arterio-Venous Anastomoses (AVA's) predominate. If the increased blood-flow was occasioned by dilation of the small arterioles of the finger-tip, one might expect noticeable capillary pulsation, which is not seen (Lovell, 1950; de Haas, 1939). Also, the capillaries are reported to be of normal size. If the blood-flow through the AVA's was increased persistently (Wilson, 1952) chronic passive congestion of the venous plexuses of the finger-tip might result. Increased formation of tissue fluid (Interstitial Oedema—Campbell, 1924) could distend the tissue spaces, which might produce proliferation of fibrous tissue, with the distribution found in clubbed fingers. This hypothesis could also explain why clubbing of the toes, nose, and ears may occur, for these areas have a relatively larger number of AVA's (Grant and Bland, 1929). It has also been suggested (Hall, 1959) that congestion of the venules under relatively high pressure with oxygenated blood would produce hypertrophy of the local tissues, analogous to gigantism in a limb with a proximal arterio-venous fistula.

Hall has pointed out that where digits are supplied purely by arterial blood—which has circulated normally through the lungs—the digits are normal. Where the blood-supply is to any extent venous, clubbing may develop. He therefore suggested that the lungs detoxicate or remove from the mixed venous blood a substance which can lead to clubbing by dilating AVA's.

Of the various vaso-active substances which have been isolated from blood and tissues, reduced ferritin or "vasodilator material" acts especially on the AVA's (Granick, 1951; Shorr, 1951), even in small quantities, it can inhibit the vaso-constriction of circulating adrenaline on the musculature of the small vessels. This substance is normally carried in the venous circulation, and after oxidation in the lungs, is rendered inert.

It is very difficult to measure the amount of reduced ferritin in the arterial blood. It can, however, be specifically antagonised by the flavinoid Rutin. On injecting Rutin, Hall showed that it increased the digital capillary blood-flow (which was reduced in clubbed fingers) as measured by a radio-active sodium clearance technique.

For this hypothesis to explain clubbing, some degree of arterio-venous shunt must be postulated. In such conditions as congenital cyanotic heart disease, this is obvious, and the clubbing can be particularly marked. To explain the mechanism of the shunt in

neoplasms of the lung, Hall has suggested a form of local reflex dilatation of pulmonary AVA's, which open in response to local irritation. This would explain the relief of clubbing, and of the symptoms of hypertrophic osteo-arthropathy, on vagotomy or hilar pneumonectomy.

Stein and Stein (1961) have shown that this hypothesis may be extended to explain clubbing associated with liver cirrhosis. Calabresi and Abelmann (1957) showed by post-mortem injection studies, that in addition to the recognised porto-caval anastomoses, porto-pulmonary anastomoses may exist. When a significant pressure gradient develops between the portal and pulmonary veins, these anastomoses could act as shunts, by-passing the lungs; and in portal hypertension following liver cirrhosis and portal vein thrombosis, this would occur. Stein and Stein (1961) described digital clubbing in a three-year-old boy who had liver cirrhosis and probable portal-vein thrombosis. Ten months after admission splenography demonstrated a porto-pulmonary anastomosis with filling of the azygos vein and opacity in the upper lobe of the right lung. Clubbing is usual in achalasia of the cardia when there is gross oseophagitis, probably with shunts—the ferritin theory could apply here, too.

It is possible that arterio-venous shunts may be demonstrable in other conditions causing clubbing, and the ferritin hypothesis might then explain the mechanism underlying the production of clubbing in many cases. Hereditary clubbing might possibly be due to some inborn fault in ferritin metabolism, resulting in the production of a form of ferritin not liable to oxidation in the lungs, but with the same peripheral action. The effects, if any, of the administration of Rutin in such cases could be very interesting. It is possible that unilateral and unidigital clubbing might be explicable in terms of arterio-venous shunt, and the supply of an element of mixed-venous ferritin-carrying blood to the digits involved.

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MUSIC CLUB—CHRISTMAS CONCERT

Christmas Concert in Southwark Cathedral, December 14th, with The Newgate Singers and Musica Medica:

Missa Brevis ..... *Zoltan Kodaly*
Brandenburg Concerto No. 5 ..... *J. S. Bach*
Magnificat in D major ..... *J. S. Bach*

A large audience came to the concert presented on 14th December by Guy's Hospital Club, and they cannot have gone away disappointed.

First and foremost, the greatest praise is due to the enthusiasm and idealism with which so many members of very demanding professions found it possible to undertake such a presentation.

Under such circumstances, however, enthusiasm cannot be matched by an equal degree of quality. And this consideration should have the principal influence on the choice of a programme. Thus a work of the supremely ordered, limpid transparency of a Brandenburg Concerto, orchestrated for a small number of instrumentalists who should all be of a very high technical standard, should have been avoided. (Its placing directly after a large, loud modern work for chorus and full orchestra was unfortunate, too, as this effectively numbed the listener's sensibility to the subtle, refined delicacy of the following work). We would nevertheless give acclaim to the highly enjoyable performances of Mr. Birnstingl (*flute*), Mr. Neary (*harpsichord*), and Dr. Gaches (*violin*), who made much of this Concerto a great pleasure to hear.

Kodaly's Missa Brevis was undoubtedly the happiest choice in this programme, benefiting by all the participants' enthusiastic contribution, without suffering from their necessarily unequal technical abilities. Here, as in the Brandenburg Concerto, the conductor's—Robert Sells'—active and conscientious preparation was apparent, and his talent and liveliness came into their own. Congratulations to him for coping so successfully with such a large number of performers and such a demanding work. Under his direction, its large architectural mass grew and stood firm throughout the performance which never sagged. With the glorious sound of the organ, the joyous chorus, and the very attractive contributions of the solo singers it rendered the mass an exciting experience.

Last came Bach's Magnificat in D major, a magnificent, and as Stephen Walsh's excellent programme notes say, unusually jubilant work. Again, the youthful "jubilance" of the performers gave much life and colour to its rendering, and in it Mr. Birnstingl in particular was at his best, contributing much with the second flautist and the oboeist, David Morton, as well as the solo singers, towards making this performance memorable. Barbara Elsey's warm-rounded voice, although not so successful in the lower registers, was an agreeable complement to Miss Strutt's sharper but perhaps more sparkling rendering. Charles Brett was most enjoyable (who could forget the delightful! "Esurientes"!), and so was Ian Partridge. With Brian Etheridge it seemed difficult for Robert Sells to establish a rhythmical accord, but the fulness of his voice was in good harmony with those of his colleagues.

I, and I think a great many other people, left Southwark Cathedral on Tuesday night with a great feeling of elation. I think this is the most gratifying result an artist can wish for, provided he can feel it, too. Many of us will look forward to similar concerts to come. But one important question mark hangs in the air this year: who will take over the role of musical director and driving force, now that Bob Sells is retiring from the scene and can no longer do so? This impending departure makes it the more appropriate that we should all express our warmest thanks to him, and also to Christopher Gaches, for doing so much and such splendid work in bringing this term's efforts in particular to such a successful end.

SILVIA RENNIE.

CORRESPONDENCE

Using the Word Cancer

SIR,—I am a secondary cancer patient, and I am concerned at the slow progress towards a freer use of the word cancer. The public and the Medical Profession are equally to blame. I am convinced that the break-down of this vicious circle of taboo and secrecy would benefit everyone.

For instance, if the General Practitioner could bring himself to use the word cancer, just once, during his first interview with a patient who comes with a lump in her breast, the subsequent relationship would be more honest and easier for both. I am writing of the simplest of cases, but I am sure that the public is now ready for this stage at least.

When the patient already has the word cancer in her mind, the sooner it is used by the doctor, the better. In so doing he joins her in her anxiety and helps her to face the possibility of such a diagnosis; when he does not do so, he is handing her back her own parcel of fears and worries, not only unopened, but sometimes sealed even more securely with yards of medico-jargon-sellotape. Even when I, an ex-Sister, was operated on in my own training hospital, nobody used the word cancer to me. Why ever not?

Cancer is the word understood by the public, and cancer is the word feared by the public. Fear is as great an enemy of early diagnosis as ignorance. I contend that a freer use of the word cancer by the patient, and his relatives and friends, by the doctors, nurses and specialists, is long overdue. I do not ask for a sweeping burst of honesty by all to all, but a steady, thoughtful and determined increase in the use of the simple word cancer whenever it is reasonable so to do.

This must eventually lead to three inseparable improvements, a happier relationship between the cancer patient and those concerned with him, a greater freedom of communication on all levels leading to improved conditions for diagnosis, treatment and research, and, lastly, an increase in public concern in fund raising, all of which bring another step nearer an ultimate cure.

Yours, etc.,

CELIA J. MEDLAM, S.R.N., M.S.R.

Hazel Hall,
West Peckham,
Nr. Maidstone, Kent.

The Towne Collection

SIR,—We were appalled to see it announced in the Medical Press recently that the wax models of Joseph Towne, in the Gordon Museum, are about to be removed.

These models have been used by thousands of students, both of anatomy and dermatology, and provided a realistic image of things they might otherwise not have seen.

We understand that the hospital tradition of these models and the fine, unrivalled craftsmanship, are of secondary importance with regard to progress, but would like to point out to readers that even today there are many who still look at them and learn from them. With the influx of immigrants we see several skin conditions which were rare hitherto and for those going abroad, there is no other chance of seeing those conditions which still exist in the tropics.

We would be grateful to know what is in fact happening to them. We are convinced that an arrangement of four tiers instead of three round the walls of the museum would accommodate all the models of skin conditions and leave space in the centre of the room for teaching. If not, we make a plea that a space be found for them to be seen in the hospital.

Yours, etc.,

E. BOWEN-JONES.
A. L. THOMAS.

East Wing,
Guy's Hospital, S.E.1.
[Ed.—See Passim.]

Frank H. Muir

SIR,—May I, through the courtesy of your columns, thank all my friends who so generously subscribed to the gift, and cheque, I received recently.

It gave me great pleasure to know how many friends remembered me, especially those from overseas and those who had left the Hospital many years ago. My gift of a tankard will enable me at all times to remember them, too, and to drink to their good health wheresoever they may be.

Yours, etc.,

FRANK H. MUIR.

33, Broad-Walk,
Blackheath,

GROSVENOR CHARLES MILLIS, M.C., M.B., B.Ch.

When the First War ended there was a very large entry of students at Guy's, most of whom had spent several years on active service in France and elsewhere. Among these was Grosvenor Millis, who entered Guy's from Queen's College, Cambridge, in 1920. Millis very quickly stood out among his contemporaries who were attracted by his friendly but modest attitude and his readiness to help in any way he could. Even as a student it was clear he had an exceptional gift for gaining the confidence and friendship of his patients.

Millis did his house appointments at Guy's and two years after qualifying he passed the M.R.C.P. and was appointed medical registrar. Some four years after qualification he went into general practice in Putney. He was also physician to the Royal Waterloo Hospital and Putney Hospital. He remained in general practice in Putney until his death on December 6th, 1965.

Millis had wide interests apart from medicine. His numerous friends at Guy's and elsewhere can look back on many happy week-ends and holidays spent with Gee, as he was known at Guy's. Perhaps the most ambitious was a camping holiday in the Scottish Highlands with four companions. Whatever the weather—and at times it was atrocious—Gee made light of disasters and maintained the morale and good temper of the party.

Millis remained in close touch with Guy's all his life. During the Second World War, when nearly all Guy's physicians were away, Millis came to the rescue and did ward rounds with students. He was a member of several Guy's Dining Clubs which he attended regularly until his fatal illness. He leaves a widow, two sons and a daughter, to whom we tender our deepest sympathy.

REVIEWS

CLINICAL PHONOCARDIOGRAPHY.

Dennis C. Deuchar, M.D., M.R.C.P. English Universities Press Ltd.

This is one of the first two books to be issued in a new series of Modern Medicine. Dr. Deuchar has set a very high standard for those authors who are to follow him.

In the last twenty years the significance of the auditory cardiac signs—well described in the last century—have been clarified by the advent of phonocardiography, at the same time as the knowledge of function in health and disease has steadily increased with modern methods of investigation, first started by cardiac catheterisation. Over the same period, cardiac surgery has made accurate anatomical diagnosis imperative and in this the stethoscope, and a trained ear attached to it, play a major part. The graphic registration of the auscultatory signs—phonocardiography—is valuable in training the ear, to discipline and verify the trained ear, and to augment haemodynamic studies in diagnosis and assessment of severity of acquired and congenital lesions which may need surgical treatment. The ability to measure phenomena factually may in itself be sufficient to augment the clinical examination and to obviate the need for more complicated and haemodynamic investigations.

The author has covered his field in 135 pages with such clarity and succinctness that this reviewer can make the honest, if rare, claim that he has read every page, and with pleasure. For a complicated and technical subject with its own terminology the text reads remarkably easily, with cross references to avoid repetition and a wealth of illustrations to clarify all the points made. Line drawings have wisely been chosen to show haemodynamic events which determine the auditory signs, though examples of phonocardiograms themselves are also shown.

As its title indicates, the object of this book is to demonstrate the clinical value of phonocardiography, and in this it succeeds admirably. For the student, what is accepted is skilfully distinguished from what is still controversial, and he will find it a stimulus to apply his stethoscope intelligently and usefully to the patient. The practitioner or consultant who is still a student would find it an admirable and quick way to revise his concepts and perfect his skill in the diagnosis and assessment of heart lesions and to assimilate the advance of knowledge in diseases of the valves and congenital heart lesions.

This book is well produced and very good value for twenty-five shillings.

C. G. BAKER.

HOW TO INTERPRET AN ELECTROCARDIOGRAM.

by Professor Camille Lian and Dr. J. Vilenski. Translated by Cornelio Papp.

This book is small enough to be kept in the pocket or carried in the handbag. The book aims to initiate the student in the interpretation of the electrocardiogram. If used as a constant reference in the wards, it could succeed in this aim. All the most important E.C.G. abnormalities are covered with the aid of many diagrams. On the debit side the book fails in not giving a full enough explanation of the basic principles of electrocardiography; it fails to show why the direction of the waves of polarisation and depolarisation is important in producing a positive or negative deflection of the electrocardiograph. A clear understanding of these facts is essential for an easy and lasting understanding of the E.C.G. Unfortunately many of the diagrams are on different scales, so comparison between them, and with real E.C.G.s is impossible. This book may help the student to recognise but not fully understand the different clinical E.C.G.s However, it may encourage the novice to further reading, but whether this is sufficient reward for the eleven shillings and sixpence needed to purchase this book is debatable.

JOHN CRISP.

MUIR'S TEXTBOOK OF PATHOLOGY.

Eighth Edition (1964). Revised by D. F. Cappell. London—Edward Arnold (Publishers) Ltd. *Price* 100*s*.

Becoming the author of someone else's book must be as difficult as taking over another's wife or computor. Though Professor Cappell brings fresh ideas to Muir's Pathology, it continues in the spirit of the old master. This edition retains the original order. Chapters serving as introduction to the general principles of pathology are followed by chapters containing a detailed description of the pathology of the systems. It is in the latter, particularly in the descriptions of the macroscopic and microscopic changes in diseased organs, that the textbook excels. The discussions on causation are presented in an interesting way, and are carefully balanced. Unity of concept is one of the benefits of single authorship.

The new edition contains completely rewritten chapters on Immunity and on the Cardiovascular, Nervous, and Locomotor systems. All other sections have been brought up to date—notably those on Neoplasia. A new chapter on common skin pathology is added.

Where the old editions failed in layout, the new edition succeeds. There are bigger, better, illustrations—and more of them. A double-columned page further helps the eye.

As a whole the book is accurate and stimulating, and now a pleasure to read. It is unequalled as the sensible guide to undergraduate pathology.

A. N. BOWDEN.

TOOTH ENAMEL.

Report of the Proceedings of an International Symposium on the Composition, Properties, and Fundamental Structure of Tooth Enamel, held at the London Hospital Medical College, 6th and 7th April, 1964.
Sponsored by: The Wellcome Trust, London; The Proctor and Gamble Company, Cincinnati; Colgate Palmolive Ltd., Great Britain; Unilever Ltd., London.
Edited by Maurice V. Stack and Ronald W. Fearnhead.
Published by Messrs. John Wright & Sons, Ltd., Bristol.

The fundamental importance of the study of enamel to the understanding of dental caries has always been appreciated. However, it is only in recent times that a concerted scientific attack has been made on the composition, properties and basic structure of enamel. This book presents within 217 pages the latest research on enamel using, among others, chemical, spectroscopic, and electron microscopical techniques.

While the specialist will find this book most informative, it is not within the scope of the undergraduate student. It consists of 22 papers read at the "International Symposium on the Composition, Properties, and Fundamental Structure of Tooth Enamel." The papers were presented by international authorities on the subject, and the participants came from nine countries.

The book is divided into four parts, each consisting of a number of contributions on the following themes:—(1) The inorganic components; (2) Chemistry of the organic components; (3) Structure of the organic components; (4) Enamel structure. It is gratifying to see that the discussion has been fully published, for the discussion is the most revealing part of a good symposium. Indeed, there are at least two good reasons why the proceedings of a symposium should be published: (a) that a great deal of scattered information is brought together under one cover; and (b) that, unlike the conventionally published papers, the contributions are critically assessed and any weaknesses or inadequacies are brought forcefully to the reader's attention in the discussion.

The editors, Dr. Maurice V. Stack and Dr. Ronald W. Fearnhead, and the publishers should be congratulated on achieving a very high standard of presentation. The emphasis of the Symposium has rightly been on the fundamental aspects of normal enamel, and only one contribution dealt in parts with carious enamel.

It is to be hoped that this Symposium marks only the first phase, and that it will be shortly followed by a symposium on carious enamel, which will receive a similar high standard of scientific endeavour.

T. LEHNER.

SPORT

It is many years since Guy's could boast regularly of international or trial players in the rugby world, and so it is particularly pleasing that W. T. Treadwell's success of last season and again this season in the English Trials, should be followed by C. W. Thorburn's selection for the final Scottish Trial. We wish them good fortune—may they meet at Murrayfield later in the year.

The Rugby Club, in fact, has been alone in showing activity over Christmas. Wins against Old Cranleighans and Esher were succeeded by a 11—0 defeat at the hands of Richmond. Guy's produced a particularly encouraging performance in the latter game, which bodes well for the impending first round cup match to take place on Tuesday, January 11th, at K.C.H. ground against St. George's (kick-off 2.15 p.m.). Coaches will be available as usual and support is invited.

REPORTS & RESULTS

RUGBY

GUY'S v. OLD CRANLEIGHANS

Saturday, 11th December, 1965.

At Thames Ditton.

Result: O.C's. 6 pts., Guy's 13 pts.

For the first time in several outings the miserable weather relented and Guy's entered the fray in good playing conditions with expectations of a much-needed victory. The Old Boy's side had suffered a 20 point defeat at the hands of another London hospital only seven days previously. Guy's were hopeful of bettering this.

However, after 10 minutes of scrappy, uncertain rugby the Hospital threequarters were penalised for being within 10 yards of a line-out, and the award was finely converted by the O.C's. (soccer style) from 40 yards. By this time an injured Osborne had retired to the wing, his centre position being filled by the erstwhile No. 8 forward, Brown.

Guy's failed, through lack of vigour and confidence, to remedy their untidy techniques. Consequently, the scrum-half, Moore, was receiving constant "bad ball" and on one of these occasions a charged down kick, followed by dribbling and interpassing, led to a try and a six point margin to the O.C's. after 20 minutes play.

By half-time Guy's had replied to these setbacks. Elliott landed a low, bullet-like penalty from 30 yards, and then the same player counter-attacked beautifully from full-back and handed on to the strong-running and deceptive Ross, who powered his way over the line, thoughtfully neglecting numerous raucously insistent colleagues whose handling during the game had been uncertain. Elliott converted.

The second half was equally inconclusive; neither side gaining overall dominance. Thus, play swung continually from end to end, but all to little positive effect.

In the loose play, the O.C's. managed to plunder the ball from the Guy's pack, even in positions when the Hospital forwards could have fed the ball quite easily (by hand and/or foot) to their threequarters.

Several "tight-heads" were taken handsomely by Hey but the lines-out were consistently frustrating due to poor technique and cohesion on both sides. Much tapping back was wild and uncontrolled with little attempt made by other responsible forwards to collect and hand on safely to the scrum-half.

Nevertheless, it was from a planned long throw to Williams at the end of the line that Guy's eventually scored a fine try. The ball passed down to Moore and then through numerous hands to Edgar, who, finding the gap created for him, ran in for three points. Elliott converted to cap a fine day's play on his part.

Having put the issue beyond doubt, Guy's then produced two superb passing movements which swept them up the whole length of the field. The latter of these nearly resulted in a second try for Ross in the last five minutes.

The spectators were justified in asking why the burst of constructive and exciting football was so transient and long-delayed. Surely they can expect a more sustained mental and physical effort from all members of the XV.

Team: D. Elliott; J. Ross, D. Osborne, A. Edgar, K. Brown; B. Rowlands, B. Moore; J. Davies (Capt.), G. Hey, R. Stansfield, P. Peace, A. Kingdon, H. Sharp, C. Neville, P. Williams.

P. SWIFT

CROSS-COUNTRY CLUB

This season, so far, has been most enjoyable, and results encouraging. We are very fortunate to have three promising freshers in B. Smith, B. Avery and G. Waterhouse. Peter Witting is the side's greatest strength. He is always up in the front in the London Colleges league races, and sustains Guy's prestige in the United Hospitals' team.

On Wednesday, 10th November, v. St. Mary's College, Twickenham, Guy's nicely defeated their second team, but University and King's College first teams also turned out to our horror and stole our thunder (coming 1st and 2nd).

On Wednesday, 17th November, we very nearly defeated Imperial College's first team for the first time. It was a very close race with much position changing, and after five miles through Richmond Park, Guy's lost by three points (38—35), but defeated Kingston and Enfield Technical Colleges.

2nd—J. Wheeler
3rd—B. Smith.
7th—B. Avery
12th—R. Wilson
14th—E. Bowen-Jones
16th—G. Waterhouse

On Saturday, 20th November, Guy's and United Hospitals bade farewell to their home course at Hadley Wood, Barnet, where we have changed in a barn behind Glebe House Nursing Home for five years. U.H. have moved to Epping Forest, but Guy's have nowhere as yet for next term's Wednesday fixtures. (Suggestions or offers by readers gratefully received!)

The match against Eton College that day was won largely by Guy's. Eton got lost coming and we didn't start till 3.45, through thick mud and fallen trees. The finish was more like a night exercise: it was remarkable everyone got home.

1st—Eton College
2nd—J. Wheeler
3rd—E. Bowen-Jones
—B. Smith
5th—Eton College
6th—R. Wilson

In the league match on 24th November, Guy's maintained their position of 8th out of 14 in the first division, still the leading hospital.

On Wednesday, 1st December, there was a relay race of four people, running 3½ miles each, organised by Borough Road College, in Osterly Park. Guy's finished 19th out of about 40 entries, including colleges and universities from Bristol, Reading, Southampton, Cambridge, Until the last lap we were the leading college of London University.

Leg.	Name.	Pos'n.
1.	P. Witting	.. 13
2.	B. Smith	.. 15
3.	D. Choat	.. 18
4.	B. Avery	.. 19

This was an encouraging result, and we extend our thanks to Borough Road for an enjoyable afternoon.

E. S. BOWEN-JONES

SQUASH CLUB

Results:

v. St. Thomas's Hospital 1st and 2nd, lost 2—3.
v. Lansdown Club, draw 2—2
v. B.P. (Cumberland Cup), won 3—2.
v. R.A.F. Cranwell, won 4—1.
v. Ebbinham S.R.C., lost 1—4.
v. Escorts S.R.C., lost 1—4.
v H.A.C. (Cumberland Cup), won 4—1.
v. Sundridge Park, lost 1—4.

Although the results do not appear very impressive, the losses were against strong club sides, and both Cumberland Cup matches were won. At the half-way stage of this competition we are leading our division by eight clear points and must be favourites for promotion at the end of this season. The draw for the individual competition has been made; it is hoped that matches will be played by the times stated and that no scratchings will be necessary.

P. DAVIS

BOXING CLUB

GUY'S A.B.C. v. METROPOLITAN POLICE

This match was staged at Ravenscourt House, the headquarters of "F" Division.

It proved to be a most entertaining evening, although it was regrettable that only three Guy's boxers were matched. The rest of the team was made up of boxers from the Lynn A.B.C.

J. Gibson was matched against an opponent who had considerable height and reach advantage, but counter-punched well and was very unlucky to lose by a points decision after an enjoyable bout.

D. Edgar sprained an ankle in the second round of his bout against rather fitter opposition but continued gamely to wear his opponent down in numerous clinches and was also unlucky to lose.

R. Stansfield was very evenly matched, but handled his opponent well, carrying the attack to him and hitting him with a number of good left hand punches. This bout was won on points.

With the assistance of the Lynn boxers the match was drawn, with three bouts each.

B. HARTLEY

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the post of **Full-time Lecturer in the Department of Dental Prosthetics.** Salary in the scale £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535, with superannuation. Appointment to date from 1st April, 1966. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Wednesday, 19th January, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Surgical Registrar at the Guy's Unit at St. Olave's Hospital,** with duties commencing as soon as possible and appointment until 30th September, 1966, in the first instance. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Orthopaedic Registrar in the Guy's Orthopaedic Unit.** Duties will also include work in the associated Hospitals of New Cross and St. Olave's. Duties to commence as soon as possible, and appointment until 30th September, 1966, in the first instance. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **15th January, 1966.**

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GUY'S HOSPITAL

HOUSE APPOINTMENTS

March 1st, 1966

Applications are invited for the following House Appointments at Guy's Hospital, due to begin on March 1st, 1966. Applications giving choice of post and choice of Hospital, in order of preference, to be lodged with the Superintendent, not later than **January 28th, 1966.**

Assistant House Surgeons
Pre-registration 4
The appointment will be for six months, the first three to be spent as A.H.S. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Surgical) or will remain as A.H.S.
These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months' appointment.

Assistant House Physicians
Pre-registration 5
The appointment will be for six months, the first three to be spent as A.H.P. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Medical) or will remain as A.H.P.
These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months' appointment.

Casualty Officer
Pre-registration *6*
House Surgeons (2)
Pre-registration 1
Pre- or post-registration 1
House Physicians (2)
Pre-registration 1
Pre- or post-registration 1
Resident Obstetrician
Post-registration 1
Gynaecological House Surgeon
Pre- or post-registration 1
Throat and Ear House Surgeon
Pre- or post-registration 1
Neurological House Physician
Post-registration 1
House Surgeon to the Thoracic Unit
S.H.O. 1
Children's House Physician
Pre-registration 1
2nd six months) or post-registration
House Physician in Clinical Pathology
S.H.O. 1
House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Pre-registration 1
House Physicians in the Department of Psychological Medicine
S.H.O 2
To commence 1.4.66.
R.M.O. in Nuffield House
S.H.O. 1
Resident Anaesthetists (2)
S.H.O. 1
Post-registration 1
Children's House Physician at the Evelina Hospital (4 months medicine, 2 months surgery, with casualty duties)
Post-registration 1
To commence 1.4.66.
(recognised for the D.C.H.)

NEW CROSS HOSPITAL

House Physicians in Medicine and Geriatrics (2)
S.H.O. 1
Pre-registration 1
The Medical Committee will also consider applications for appointments at outer hospitals as follows:—

BECKENHAM HOSPITAL

House Surgeon
Pre-registration 1

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases
Pre-registration 1
To commence 28.3.66.

JOYCE GREEN HOSPITAL

House Physician
Pre-registration 1

LEWISHAM HOSPITAL

House Surgeon to Mr. Cavendish
Pre-registration 1
From 1.3.66.
House Surgeon to Mr. Le Brun
Pre-registration 1
From 3.3.66.
House Physician to Dr. Llewellyn Smith
Pre-registration 1
From 16.3.66.
Locum from 1.3.66.

ORPINGTON HOSPITAL

House Surgeon with Physical Medicine
Pre-registration 1
To commence 1.4.66.
(Locum from mid-March)

QUEEN MARY'S HOSPITAL, SIDCUP

House Physician
Pre-registration 1
House Surgeon
Pre-registration 1

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's, therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts is available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectively. A candidate who has completed his first six months in a specialty (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

P. J. HELLIWELL,
Acting Superintendent.

January 3rd, 1966.

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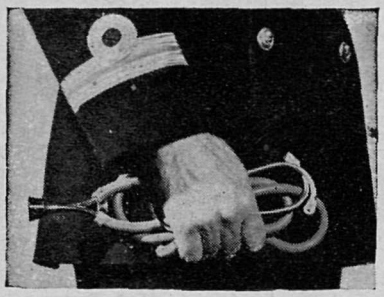

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PRIZE LIST

GUY'S HOSPITAL DENTAL SCHOOL

PRIZE IN GENERAL SUBJECTS, NOVEMBER, 1965

The following Awards have been made:—

Hock, Miss J. M.
Robinson, R.
} First and Second Prizes to be shared.

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R. C. Day
D. H. Enderby
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M. E. French
M. J. Lindop
C. C. Penney
J. D. Powell-Jackson
P. Randell
P. G. Ransley
R. O. Robinson
R. B. Stott
Mrs. D. A. S. Watson
S. Worthington

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R. A. Reekie

Part 2. Principles and Practice of Surgery

D. R. J. Quickenden
*B. S. Ricketts

*Has completed the examination.

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M. N. J. Jacoby
J. M. Justice
R. D. Lee
L. A. Lees
R. G. May
W. A. Norman
J. H. Ransford
D. J. H. Richmond
M. J. Sharman
Julia A. Stanton-Rice
S. Talbot
A. Thomas

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PERSONAL

If there is anyone who might be interested in joining a party to visit the Austrian Tyrol for a ski-ing holiday in February, please would they contact The Secretary, Guy's Gazette (telephone number HOP 7600, extension 257), who will supply further details.

CHANGES OF ADDRESS

Dr. and Mrs. N. J. Barwell, to 108, Addison Road, Guildford, Surrey.

Dr. and Mrs. M. Steyn, Pump Cottage, 334a, Seafront, Hayling Island, Hants. Telephone: Hayling Island 77133.

BIRTHS

BARR.—On December 11th, to Alan and Margaret Barr, a daughter, Abigail Margaret, a sister for Francis, at Nuffield House.

BARWELL.—On November 20th, to Anne (née Thomas, S.R.N.) and Nick Barwell, a son, James Robert.

PATON.—On December 18th, at Bridgewater, Somerset, to Dawn (née Wood, S.R.N.) and Frank Paton, a son, brother to Anna, Julian and Catherine.

STEYN.—On December 12th, at St. Mary's Hospital, Portsmouth, to Barbara (née Mehta) and Michael Steyn, a son, Richard John.

STRUBE.—To George and Gillian, a son, Peter, a brother for Jacqueline and Roland. Southmeads, 33, Goffs Park Road, Crawley, Sussex.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

DEATHS

BARNICOT.—Elizabeth Jessie (née Lucas), died peacefully on 3rd December, 1965, aged 85 years. Mrs. Barnicot trained at Guy's Hospital from 1907—1912 and will be remembered by her friends, particularly during the period when she was Home Sister from 1910—1911.

POST.—On Christmas morning, 1965, suddenly at the West London Hospital, Horace W. A. Post, M.D., D.M.R.E., aged 61, of Middle Farm House, North Barrow, Yeovil, Somerset, most beloved husband of Daphne and loving father of Carolyn and John.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2021

PASSIM

Shifting with the times

On the 2nd of January, 1966, the Guy's Nursing Staff altered their time-table to a 42-hour week and shift system. These changes, and some of the reasons for their introduction, are outlined by the Matron later in this edition. At such a time of change, however, it is, perhaps, interesting to compare the new conditions with those prevailing one hundred years ago.

In the Wills library there is a fascinating booklet on Nurses, written in 1857 by John F. South, an eminent Surgeon of St. Thomas's Hospital. It was written in direct opposition to the proposals that were being put forward at the time by Florence Nightingale and others, for instituting an official training school for nurses. The work was initially intended as a letter to "The Times", refuting a previous letter in that paper which had seriously deprecated the standard of nursing of the day, but Mr. South found that there was too much to say to be confined to a short letter. He. instead, takes the opportunity of slaying evil rumours and gallantly defends, among other things, the morals of the profession—about the suggestion that nurses are "tempted and seduced if young and well-looking", he says "that this is false I unhesitatingly affirm." He goes on to say, "As to nurses being ' sworn at by surgeons and bullied by dressers,' I assert that this statement, as regards St. Thomas's Hospital, is simply untrue."

However, the special interest in the booklet is the account he gives of the hours worked by the nurses of the day.

"She (the day-nurse) comes on duty at six o'clock in the morning and remains till eight o'clock in the evening, after which she retires to sup and sleep among her fellows in a spacious dormitory specially allotted to them. But though these are her regular hours, she, as well as the Sister, is liable to be kept up all night.

The night-nurse comes on duty at eight o'clock in the evening, and remains on watch, moving continually about the ward, till six o'clock of the following morning, when the day-nurse arrives . . . her watch over, she remains till eleven o'clock assisting to clean up and put the wards to rights. . . . She receives weekly wages but has not any rations except beer." He goes on:—

"It may be passingly noticed in reference to the wages of the sisters and nurses, that the former are pretty fairly, certainly not *too*

lavishly paid. The nurses, however, in my opinion, are for many reasons too scantily remunerated."

This concluding remark is, perhaps, notable in being the only thing to remain true to this day.

War in the Park

First of all they started trampling over the flower beds. Then they built fortifications guarding the entrance to the Nurses' Home and concealed their activities. High walls of an unconvincing brown material disrupted the familiar line of the park. Invasion seemed imminent. Only the self-conscious who cross the park with eyes fixed to the ground didn't notice. But time passed and the only indication of tension was the demolition rubbish littered on the lawns. Obviously, road blocks were to be the next step.

Now the strategy of the new defences have taken on a subtle change for they have been camouflaged in hideous green so that we can pretend we can't see them—rather like the idea of putting soot on the new brick of the East wing. Perhaps it is all an embarrassing mistake and someone will tell them that the war is over and that the Nurses' Home no longer needs such laudable defences. They could then continue the alterations to the Nurses' Home and clear up the rubbish in the park.

On a recent visit to New York, Lord Brock was presented with the Bronze Medal of the City of New York by the Mayor, for his contributions to Surgery.

Mr. D. N. Ross (Thoracic Surgery), Dr. J. Ersting (Physiology), Dr. D. B. Gower (Biochemistry) and Dr. R. G. Spector (Pathology) have each been recognised as Teachers in their respective fields, by the University of London.

GUY'S DIARY

Exhibition:			Burns.
JANUARY			
22nd	S.	10.00	Clinico-Pathological Meeting. In the Clinical Theatre.
24th	M.	1.00	Clinical Lecture. Mr. CANN.
25th	Tu.	1.00	Clinical Lecture. Dr. BISHOP. "A new look at the Thyroid."
27th	Th.	1.00	Clinical Lecture. Mr. GLOVER.
28th	Fr.	1.00	Clinical Lecture. Dr. KAUNTZE. "Carcinoma Bronchi."
28th	Fr.	2.00	Combined Round. Professor Butterfield and Dr. Avery Jones.
31st	M.	1.00	Clinical Lecture. Mr. LEWYS-LLOYD, of St. Olaves Hospital. "Carcinoma of the Stomach."
FEBRUARY			
3rd	Th.	1.00	Clinical Lecture. Dr. HILLS
4th	Fr.	1.00	Clinical Lecture. Dr. TROUNCE. "Some Disorders of Hydrogen Ion Homeostasis."
4th	Fr.	2.00	Combined Round. Professor Butterfield, Professor Hunt, and Professor Adams.

The Tortoiseshell Tom Cat —a Feline Example of Klinefelter's Syndrome

E. J. MOYNAHAN, F.R.C.P.

The origin of the male tortoiseshell cat is one of the minor problems which has perplexed biologists for a considerable time. A feature of the inheritance of tortoiseshell coat-colour in the cat is that few of the animals displaying it are male and, of those that do so, the great majority are sterile. Geneticists have shown particular interest in this anomalous situation and many hypotheses were put forward to account for the observed inheritance of the character, but none up to the present has been able to withstand rigorous criticism. However, the problem would now seem to be partially, if not completely solved as it is clear that most of the male tortoiseshell cats are feline examples of the Klinefelter's syndrome, since it has recently been found that the males are chromatin positive and also possess 39 chromosomes instead of 38 which is the normal diploid complement of the species.

Historical

Doncaster, as far back as 1904, was one of the first to study the genetics of the male tortoiseshell in the light of the then newly re-discovered Mendelian laws. He remained interested in the problem throughout his life and in a subsequent paper (1920) he suggested that tortoiseshell toms were genetic females which had undergone partial or total sex inversion as a consequence of chorionic vascular anastomosis with another kitten in the same litter—a condition analogous with free-martins in cattle. Doncaster's hypothesis was abandoned because of lack of evidence of any anatomical gradations between males and females due to sex transformation (Bamber, 1927) and the failure to demonstrate any vestigial female reproductive organs in tortoiseshell males (Wislocki and Hamlett, 1934). The discovery of erythrocytic mosaicism in a fertile woman whose co-twin, a male, had died before reaching adulthood (Dunsford *et al.*, 1953) lead Sprague and Stormont (1956) to review the evidence in the light of increasing knowledge of the consequence of chorionic vasculature anastomosis in different species of mammals. When heterosexual vascular anastomosis occur there are four possible sequels in terms of sterility; (1) No sterility may follow, as had been shown to occur in marmosets (Wislocki, 1939); (2) the female might be sterile and the male fertile as in cattle (Lillie, 1916), goats (Keller, 1920), pigs (Hughes, 1938) and sheep (Stormont, 1954); (3) the male may be sterile with the female fertile or (4) both may be sterile. They thought that the third possibility was the case with the tortoiseshell tom-cat. Their hypo-

thesis raised two important questions, viz.: what is the incidence of sterile males and what is the frequency of synchorial litter males in the general cat population, without answering these with any accuracy their conclusion remained speculative.

Tortoiseshell Toms in Japan

There is a belief in Japan that a tortoiseshell male cat brings good luck to a house, so much so that the birth of such a kitten is deemed worthy of report in the local newspaper. It is not surprising, therefore, to find that the interest of Japanese geneticists was aroused nor that material was available for study, both histological and cytological and that advantage was taken of the opportunities by Komai and Ishihara (1956). By this time it was clear from statistical survey by Komai (1952) that the gene for orange colour (O) in cats is sex-linked whereas the gene for tabby (bt) or black (b) is autosomal. Searle (1949) had arrived at the same conclusions from his studies of coat colour in London cats, although the incidence of gene O was only a little over 10 per cent in London but ranged from 25 to 40 per cent in Japanese cats. It was thought from these surveys that O, either homozygous O/O or hemizygous obliterates the effect of the autosomal gene for black (b) or tabby (bt) and gives an orange coat, but in the heterozygote O/O^t it allows the effect of the tabby gene to appear partially—hence the tortoiseshell coat. Komai was able to collect records of 65 tortoiseshell toms and of these he was able to examine 24 personally. The testes of four sterile animals were examined by Ishihara, who found gross deficiency or total lack of germ cells, in agreement with previous findings, whereas the testes from apparently fertile tortoiseshell males appeared to be histologically normal in every respect. Cytological studies revealed a usual diploid chromosome number of 38 chromosomes with a distinctly unequal X-Y pair. In explaining their findings they suggested that the exceptional tortoiseshell males must be heterozygous for the O gene and since O is a sex-linked gene it should be located in the Y chromosome. This could happen if O is only partially sex-linked and occasionally cross-over from X to Y was to occur and the Y carrying O meets an X which causes its allele O. They had to postulate existence of a further gene for fertility in the male and also situated in the Y chromosome. They thus had to allow for a dual origin of the male tortoiseshell and there the matter rested until quite recently.

Klinefelter's Syndrome in Man

Meanwhile in 1942, Klinefelter, Reifenstein and Allbright described a syndrome in man consisting of gynaecomastia with small testes which, on histological examination, revealed hyaline changes in the seminiferous tubules, apparently normal Leydig cells and azoospermia. Three years later Heller and Nelson (1945) were able to add to our knowledge of the syndrome by showing that when testicular failure occurs early in puberty there is marked eunuchoidism but no gynaecomastia, whilst at a slightly later stage gynaecomastia is moderate and some degree of secondary sexual development occurs, but should the testicular failure not develop until late in adolesence then the secondary sex changes are normal although gynaecomastia is marked.

As will be seen later, Klinefelter's syndrome is associated with a characteristic complement of chromosomes or karyotype in a majority of cases in which there is usually an extra X chromosome, yielding an XXY constitution, and it has been estimated that more than one in every thousand males in the British population show this, though a far smaller proportion exhibit the syndrome in any of its clinical forms. It would seem likely that man is not unique among mammals in this respect and when the cytogenetics of this syndrome were reasonably well established its occurrence in other species was sought. Due caution must always be observed in extrapolating results obtained in one mammalian species to another and in no field is this caution more imperative than genetics.

Sex Determination in Mammals

Apart from a few species, all mammals so far studied have an XX–XY type of sex chromosome mechanism, the male being the heterogenetic sex. In that classic genetic test organism, the fruitfly *Drosophila melanogaster,* there is also an XX–XY mechanism and it has been known for 30 years or more that sex is determined as a result of a balance of female determinants on the X chromosome with the Y chromosome playing an inert role, although essential for male fertility. This was thought to be true for mammals until the discovery by Barr and Bachem in 1949 that there was a sexual difference between the nuclei of the cells of the central nervous system in the cat. A few years later it was established that this sexual dimorphism was present in cells of other tissues (Graham and Barr, 1952) and in 1953 it was shown that the skin in man could be "sexed" with a high degree of accuracy (Moore, Graham and Barr, 1953). The nuclei from females show a mass of chromatin lying on the nuclear membrance, whereas such cells from males generally lack this feature. The cells are referred to as "chromatin-positive" and "chromatin-negative" respectively and the procedure is known as "nuclear-sexing". Following on this, Professor Polani, of this hospital, collaborating with Drs. Lennox and Hunter, studied the sex-chromatin in skin biopsies obtained from three female patients with ovarian agenesis and coarctation of the aorta, a congenital cardiovascular anomaly which appears to be predominately a male disorder. The skin cells from all three patients were "chromatin-negative", indicating a male sex karyotype. Gonadal dysplasia or ovarian agenesis is usually unrecognizable clinically until the patient reaches puberty unless the patient has other anomalies such as webbing of the neck, congenital heart disease, renal tract anomalies and the like. Professor Polani's findings were soon confirmed over here and in the United States, but in the larger series studied it was found that a number of these patients were not chromatin-negative.

It became important to establish the identity of the extra chromatin present in the nuclei of females and it was proposed by Barr (1955) and Lennox (1956) that it corresponded with the heterochromatin of the two X chromosomes and this was found to be true by Reitalu (1957) and Klinger and Swarzacher (1958). However, the finding of apparently anomalous cases meant that "nuclear

sexing" alone could not be accepted without further corroboration, and Professor Polani, with Dr. Lessof and Dr. Bishop, in 1956 sought evidence which did not involve cytogenetic techniques but at the same time could satisfy more rigorous genetic scrutiny. They found that colour blindness occurred in the patients with gonadal dysplasia frequently enough to favour the idea that such patients possessed only one X chromosome, so that their Karyotype could be either XY (male) or XO with a complement of 45. They could, of course, have arisen parthenogentically but Stanton (1956) showed they were not haploid.

At the same time workers elsewhere had found that the karyotype and phenotype did not correspond in Klinefelter's syndrome, since a majority of the patients, though somatically male, had sex chromatin in the nucleus of the cells examined (Nelson 1955, Plunkett and Barr 1956, Bradbury *et al.* 1956). Once again the possibility of a human free-martin was considered but appeared less feasible than the genetic cause and Plunkett and Barr put forward the hypothesis that the karyotype was XXY in this syndrome.

The Guy's group then proceeded to test the latter hypothesis by colour-vision studies for presence of more than one X chromosome and none was found in fifty-five such individuals (Polani *et al.*, 1958). Further cases studied confirmed this (Polani, 1962). However, the picture is not clear as it looks at first sight and it seems that the cytogenetic situation is almost as varied as the syndrome itself, following the report that three patients with Klinefelter's syndrome were colour blind but the father of each patient had normal colour-vision (Nowrakowski, 1958). This certainly put the cat among the pigeons, but your cytogeneticist is never at a loss for a hypothesis, and suggesting that these anomalous findings could be accounted for by deletion or loss of part of the X chromosome involving the locus for colour-vision, and a hypothetical locus for gonadal development, the German workers were able to put forward a plausible explanation for the anomalous findings, as there would still be ample heterochromatin to give a typical female nuclear sex pattern. Even more complicated hypothesis have been offered to account for Klinefelter's syndrome, some of which involve commitment to theories of sex determination at present unproved such as that of Stewart and his group in which it is postulated that chromatin balance is upset by either loss or duplication of hypothetical masculine loci, so that excess of these would turn a female into a male but deficiency would tend to feminize a man.

Although the situation may seem a little confusing, especially to the student, this is not without pedagogic value because it should serve to make the student think things out for himself and illustrates very well the application of scientific method to medical and indeed to many biological problems. Textbooks rarely emphasise how much science begins as pure speculation in which a hypothesis is put forward and then tested by observation and/or experiment. Hypotheses remain valid only for as long as they can account for the known facts and any hypothesis which cannot be tested cannot be scientific.

Polyploidy in Animals and Extra Somatic Chromosomes in Man

Polyploidy is defined as the multiplication of the normal chromosome number of the species. Thus should the normal diploid number of chromosomes (2n) be 10 then all multiples of 5 higher than 10 are polyploids and individuals with 3n chromosomes are said to be triploid, 4n are tetraploid and so on. Polyploidy is widespread in plants in which it is an important mechanism for species formation, indeed, it has been estimated that more than one out of every three of the existing species of plants has arisen by polyploidy. In striking contrast to the state of affairs in the plant kingdom, polyploidy is very rare in animals and is virtually confined to those species which have abandoned sexual reproduction and reproduce parthenogenetically or by self-fertilizing hermaphroditism. The reason for this rarity of polyploidy in animals is still a matter of great controversy among biologists and several very different attempts have been made to explain this rarity. (Earwigs are the only bisexual polyploids.) Of these, one of the earliest was that of Muller (1925) who, accepting the general belief that sex is determined by a balance of sex factors which may be distributed over the autosomal chromosomes as well as sex chromosomes, pointed out that the offspring of polyploid individuals in which the females are XXXX, for example, and the males XXYY, would be partially sterile since many would have the constitution XXXY. This karyotype would be selected against thanks to the reduced fertility.

Stebbins, in his "Variation and Evolution in Plants", has suggested that polyploidy might interfere with cellular differentiation in animals because development is a more complex affair in them than it is in plants. There is supporting evidence for this from what we know of the identified trisomy syndromes in man where the presence of even one extra autosomal chromosome is sufficient to interfere with the development of the aneuploid individual so that gross malformations result, in most cases incompatible with independent existence. The known trisomic conditions in man include the 21st chromosome pair, giving rise to Mongolism (Down's syndrome), 13th pair yielding severe cerebral, ophthalmic, cardiac, renal, and other defects, including congenital aplasia of the skin, and 17-18 group. No doubt other anomalies remain to be discovered but it seems clear that the animal zygote will only tolerate an excess of sex chromosomes if anything approaching normal development of the individual is to proceed. However, polyploidy does not seem to interfere with the development of parthenogenetic animals such as earthworms, and we know that many of our cultivated plants are polyploid. Polyploidy has only been reported in one mammalian species, a hamster, but even this instance is disputed (White), and the highest number of chromosomes reported in man so far is 69, in which there was a complete triploid set with XXY sex constitution and the patient, a male, had multiple malformations as well as severe oligophrenia. Tumour cells, of course, may be and often are polyploid.

It would seem clear that the scarcity of polyploids in animals is a direct consequence of bisexuality which necessitates a special mechanism whereby sex is determined by segregation of a pair of

differentiated sex chromosomes X and Y or an unpaired X chromosome. The fact that one of the two sexes has two different types of gametes X and Y or X and O (where O denotes absence of the other sex chromosome) obviously may lead to situations producing sterility or sexual anomalies, which indeed we have been discussing. As a matter of historical interest it is worth recalling that Henking, in 1891, was the first to notice a "peculiar chromatin element" when he was studying spermatogenesis and McCleng thought it to be an accessory chromosome, later in the decade, but he soon realised that it may play a part in sex determination. The role of the sex chromosomes was, of course, soon established with the rise of classical genetics, but it is by no means clear how the genes determining sex achieve their object. In man at least, it seems likely that the female is the "neutral" sex and unless masculine genes are present the primitive gonad of the embryo will differentiate into an ovary and give rise to the accessory structures characteristic of the female. The role of sex hormones in modifying and reversing the secondary sex characters is well known and it may well be that the gene or genes for maleness may act by controlling the synthesis of a hormone, probably steroid, in the embryo at a certain critical period in development and thus set in train the various processes which result in the male somatotype. It is quite possible that one gene alone may be concerned since it may require only a few molecules of the postulated hormone to achieve direction of development along male lines. If this gene is not present or is suppressed then development proceeds along female lines. There is evidence, some of which we are now considering, that sex in the cat and mouse is determined in a manner not grossly dissimilar to that in man.

Extra Sex Chromosomes in Man and Animals

Following on the work of different observers on the karyotypes in Klinefelter and Turner's syndrome in humans, it was soon established by Russell in the U.S.A. that the XXY and XO constitution could be obtained by suitable breeding experiments, subsequently confirmed cytologically (Russell and Chin, 1961). The animal storing XXY was viable, normal in size and phenotypically a male with normal male mating behaviourism but apparently sterile. It is clear from these observations that the Y chromosome in mammals, unlike that in the fruitfly, is strongly male-determining, a conclusion which has been further emphasized by the finding of additional aberrant sex-chromosome types in man, viz., XXX, XXXY, XXXX and XXYY. There are a few exceptional mammalian species in which XO males occur, which would seem to suggest that male determination by the Y chromosome does not apply to all mammals, but White (1961) has offered cogent reasons for believing that some, at least, of the exceptions can be explained by the probability that the Y chromosome is not lacking but is fused to another. The possibility that the male tortoiseshell might represent a chromosome abnormality analogous with chromatin-positive Klinefelter's syndrome occurred to Thulene and Nasby (1961). They sought for evidence of sex chromatin of "female" type in the affected males and expected to

find at least one extra chromosome of the X type to give a complement of XXY. These cytogenetic abnormalities should be present in phenotypic male with abnormal seminiferous tubules and failure of spermatogenesis leading to clinical sterility. They obtained buccal smears from 12 suspect cats and found that 2 were chromatin-positive, white blood cells from these cats were then grown in tissue culture and chromosome counts were obtained which showed that 39 chromosomes were present instead of the usual complement of 38. In all these recent studies the coat colour merely serves as a screening device, since it should be quite clear that there is no reason why this abnormality (XXY) should be limited to tortoiseshell males, any more than it is to colour-blind men, and there may be more XXY (Klinefelter) cats with black or tabby cats.

The Lyon Hypothesis, Mosaicism and Coat Colour in Cats

A satisfactory explanation of coat colour in tortoiseshell cats is provided by the hypothesis put forward by Dr. Mary Lyon in 1961, following the demonstration by Ohno and Hauscha (1960) that one chromosome in the cells of various tissues of female mice was heteropyknotic, they considered this chromosome to be an X and suggested that the so-called sex chromatin was, in fact, the heteropyknotic X chromosome. Lyon exploited sex-linked genes for coat colour in mice in her breeding experiments, since female mice heterozygous for such genes have a mosaic phenotype, not unlike the situation in the tortoiseshell cat. She formulated the following hypothesis as a result of these experiments (1) that the heteropyknotic X chromosome was genetically inactivated, (2) that it could be either paternal or maternal in origin in different cells of the same animal, and (3) that the inactivation occurred early in embryonic development. She later (Lyon, 1962) extended the hypothesis to cover gene action in the X chromosome of all mammals including man, so that in the adult female, whether cat or woman, every tissue is a mosaic of cells in which one or other of the two X's is inactivated; indeed, only one X can be active in any cell, which might explain the viability of individuals with three or more extra sex chromosomes (e.g. XXXY). Mosaicism is fairly easy to detect with genes displaying coat colour, and it has also been demonstrated in women for the Duchenne type of muscular dystrophy and glucose–6–phosphate–dehydrogenase deficiency; it probably occurs in some women with ectodermal dysplasia of the sex-linked type, and no doubt other conditions as well.

Returning now to the tortoiseshell cat it was not surprising that geneticists became interested again in the problem, nor was it long before it was found that the sterile males were of XXY karyotype and were therefore capable of producing patches of both yellow and black through possession of two X's each bearing a different allele.

Tortoiseshell Toms and Human Klinefelters

The analogy between tortoiseshell males and Klinefelter's syndrome in man is very close. In both we find phenotypic males, with abnormalities in the development of the tubules of the testis as well as azoospermia associated with sterility. The infertile tom shows mating behaviour though some are timid and show no interest in females in the breeding season. Both feline and human cases show

positive sex chromatin in the buccal smears and chromosome counts following tissue culture show that there is an extra chromosome in both species, yielding a sex chromosome constitution of XXY. The fact that some of the tortoiseshell males are fertile should serve to remind us that we are likely only to meet with and consequently to be able to recognise the extreme cases in the clinic and that many human XXY individuals must be virtually normal. Nevertheless, the cytogenetic abnormality is a serious one, carrying with it the severe penalty of infertility and is a further reminder of the reluctance of the animal nucleus to accommodate more than the normal complement of chromosomes and illustrates very clearly the mechanism whereby abnormal genetic constitutions are rapidly eliminated from a breeding population. It would seem that there is a limit to the amount of genetic "information" which the chromosomes can carry inside the nucleus of the animal cell, and if too much is present (in the form of polyploidy or extra chromosomes) then instead of a lucid and unambiguous "directive", conflicting instructions are given to the developing embryo resulting as it were in epigenetic "noise" leading to malformation, sex anomalies or in most cases the early death of the "confused" embryo; even an extra X results in mental impairment.

Conclusion

Human and for that matter mammalian cytogenetics is still in a very early stage of development. It has increased one's understanding of the relatively common anomaly known as Down's syndrome (trisomy 21), has brought to light the cause of several other syndromes and has lead to a better understanding of sex anomalies in man. These findings in turn have lead to important advances in animal genetics, illustrating the cross fertilising action of scientific medicine on other disciplines and reminding us that science has its debts to medicine, so that the traffic is not all one-way. No doubt the future will reveal cytogenetic anomalies in other mammals which will have a direct bearing on human pathology and maybe help us to prevent or remedy some of the very crippling conditions and save parents the tragedy which any attempt at polyploidy brings as an inevitable consequence.

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OBITUARY

HEAD NURSE GILLIAN C. AXTELL

The tragic death of Gillian Axtell, in a car accident on Sunday, December 19th, 1965, filled us all with deep sorrow and horror.

It is a not infrequent occurrence to read of tributes to men and women who have given long years of service, and attained great achievements in a variety of fields. This is salutary—but length of time and weight of contribution are not necessarily synonymous.

Gillian Axtell was a typical representative of this magnificent rising generation of Guy's nurses. Gillian was twenty-one years old, highly intelligent, vivacious and adaptable—a splendid nurse and an asset to her colleagues.

Gillian Axtell's time at Guy's was cruelly curtailed, perhaps this should serve as a reminder of how much we owe to this generation, upon whom the future of Guy's will depend.

A.M.J.

SOME QUESTIONS AND ANSWERS

Medicine has many aspects but all are, or will be, open to study by scientific methods. As always, effective doctors of the future will need to know the natural history of their patients' complaints. Who has them? What is their natural outcome? What are the significant points in diagnosis? What errors are commonly made in diagnosis and treatment? This kind of information can be studied by the scientific method. The papers of Wayne and his colleagues (1960)* on the disorders of thyroid function are an example. The introduction of a new, effective form of treatment has often shown that we have inadequate knowledge of the outcome of common forms of illness. Accounts of the natural history of disease are now much easier to write because the results of study can be stored and analysed in computers. Nevertheless, the computer can answer only questions which are put to it.

That medical knowledge has another aspect was recognised by Pasteur: "Without theory, practice is but routine borne of habit. . . ." Knowledge of this kind is concerned with the mechanisms of disease and death. As yet we do not know the train of events which causes death in septicaemia. Neither do we fully understand the mechanism of production of many physical signs, nor the ways in which the effects of such abnormalities are offset. This part of medical knowledge is concerned with such questions as what is the first event in the accumulation of oedema? If it is sodium retention, is the initiating stimulus the same in cardiac failure as it is in nephrosis? Where is the receptor which detects this initiating stimulus? Does the sodium retention depend upon the hypersecretion of adrenal steroids? Answers to these questions often depend upon a specialised knowledge of function and its disorders which very few can carry in their minds. But the application of this type of knowledge to the care of patients is usually only fully effective when the methods by which it was obtained are understood.

In the belief that this kind of approach to medicine needs encouraging, some questions in this vein have been prepared and are printed below. The correct answers, or what are considered to be so, will be found on page 44 of this issue. The questions are of two sorts. To answer some no knowledge of any sort is required, merely a willingness to select the relevant pieces of information set out in the question. In others the information required is not included in the question, but in both types a reference to the paper which prompted the question is given. This should encourage the criticism of papers purporting

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*WAYNE, E. J. 1960. Clinical and Metabolic Studies in Thyroid Disease, Brit. Med. J. Vol. I, 78.

to explain the mechanisms of disease. It is hoped that the use of the library will increase. To increase realism some questions have been larded with information which is of no value in answering them.

Many of us have inadequate understanding of clinical terms. In an attempt to remedy this, medical terms and clichés have been deliberately introduced into some of the questions to promote reference to books and colleagues for clarification.

I am grateful to my colleagues for their questions and answers. Any credit is theirs, but I shall welcome constructive or adverse criticism, either of the questions and their answers, or more important, of the idea underlying this activity. Further questions and answers of the same general type would be very welcome.

J. N. HUNT.

QUESTIONS

Series A.

Some patients with uraemia are anaemic.

See: Clin. Sci. 1965 **29**, 407 ibid. 1957 **16**, 163.

Q.1 In what units would you measure anaemia?

Q.2 Is anaemia necessarily associated with decreased red cell mass?

Q.3 In what units would you record red cell mass?

Some patients with uraemia and anaemia have a decreased red cell survival time. Such cells transfused into normal patients survive normally.

Q.4 What does this indicate about the cause of decreased survival in patients with uraemia?

Q.5 How would you decide on this point?

Series B.

The total number of red cells and the total volume of plasma can be measured simultaneously by the injection of red cells labelled with $^{32}PO_4$ and ^{131} Iodine labelled albumen.

See: Veall and Vetter. Radioisotope techniques 1958.

The ratio of cells to plasma (haematocrit) is higher in the blood drawn from a large vein than in the whole body.

See: Clin. Sci. 1956, **15**, 557.

Q.6 What does this indicate about the blood in the capillaries?

A man with a known blood volume of 5 litres suffers a measured haemorrhage of 1 litre. After 1 hour his venous haematocrit is found to be 45% (within normal limits).

Q.7 Is this result consistent with the history?

Q.8 Assuming this 1 hour result is technically correct, what was the blood volume at the time blood was taken for the haematocrit estimation?

See: Annals of Surgery 1964—**160**, 263.

Q.9 What would you expect the haematocrit to be after 24 hours?

Series C.

There were seven patients with rheumatoid arthritis, three with periarteritis nodosa, one with systemic lupus erythematosus, one with dermatomyositis, and one with temporal arteritis.

See: Clin. Sci. 1965, **29**, 533.

Q.10 What have these patients in common?

The concentration of γ-globulin in the sera of such patients is frequently higher than normal, but remains constant. The rate of synthesis is also often increased.

Q.11 Does a normal concentration of γ-globulin in the serum give any certain information about the reactivity of the immune apparatus?

Q.12 What do you understand by the term immune apparatus?

Series D.

In man the output of urobilinogen in the stools is reduced to nil by broad-spectrum antibiotics. There is no urobilinogen in the faeces of germ-free rats.

See: Brit. Med. J. 1965. pp. 1510.

Q.13 What conclusions do you draw?

The output of urobilinogen in the urine increased as the pH of the urine was raised by giving sodium bicarbonate.

Q.14 Is this consistent with urobilinogen being a weak acid or a weak base?

The dependence of rate of urinary excretion upon pH applies also to exogenous substances. Salicylic acid and pheno-barbital are weakly acidic; amphetamine and mecamylamine are weak bases.

See: Am. J. Med. 1964, **36**, 743.
Brit. Med. J. 1957. pp. 1219.
Lancet 1965. p. 303 ibid. 1966. p. 83.

Q.15 In which directions would you alter urinary pH in order to increase the output of these drugs?

Q.16 How are these effects explained?

(Answers — page 44)

NOTICES

New Rotas of Duty for the Nursing Services

During the last few years it became increasingly obvious that the whole current pattern of on duty rotas for day and night staff was in drastic need of total revision. Night Staff in particular lived an extraordinarily unreasonable pattern of life—whilst non-resident staff ran a probable close "second" amongst those groups whose commitments weighed heavily against any reasonable combination of professional life, and domestic calm! With commuting becoming steadily more costly: traffic blocks daily more congested: the marriage age falling year by year—and clear statistical evidence that the numbers of women likely to join the nursing service in the last lap of the twentieth century would fall, *something* had to be done!

In February, 1964, a circular was received from the Ministry of Health advising the hospitals that a 42-hour week for nursing staff should be implemented—preferably without undue delay—but certainly by 1st January, 1966.

In the months which followed, a good deal of discussion and planning ensued and a variety of possible schemes were assessed. Progress was slow, chiefly because of the extreme difficulty involved within the whole problem of reducing both the work load, and the hours undertaken by the night staff. Certain small schemes were attempted, but again with little real success.

In August, 1965, all Sisters responsible for bed patients were circulated with a brief questionnaire, requesting their own views. 77.9% of these Sisters voted in favour of a Shift System of duty rotas.

Now, we have embarked on this new scheme, which is, as yet, too young for full comment. It is certainly abundantly clear that the patients are delighted: their timetable is more in keeping with that lived at home. The day begins at 7 o'clock—and breakfast is at 8.15 a.m.—cooked by ward orderlies. The patients' lunch is served at 12.45 p.m.—tea at 4.30 p.m.—supper at 7.15 p.m., and lights out at 10 o'clock.

Several sections of the Hospital Staff are finding it easier to complete their specific commitments within the wards before lunch.

The Nursing Staff work three Shifts as per:—

Shift "A"— 7.30 a.m.— 3.15 p.m.

Shift "B"— 2.15 p.m.—10.30 p.m.

Shift "C"—10.15 p.m.— 8.45 a.m.

Prior to a day off, nurses essentially work Shift "A"—but complete their duties at 2.45 p.m. and then return for duty 48 hours later.

The Sisters do not begin Shift "A" until 8 o'clock, and have a free week-end fortnightly from 2.45 p.m. on Friday until 2.45 p.m. on Monday.

Inevitably, certain areas of the Hospital are experiencing particular teething problems: without doubt we shall improve the organisation as circumstances permit. Meanwhile, I am sincerely grateful to the many sections of the Hospital Staff for their industry and support.

A. M. JOHNSON, Matron.

Rugby Club Annual Ball

The Annual Ball of the Guy's Hospital Rugby Football Club will be on Wednesday, 9th March, at Quaglinos. Guests will be received at 8.30 and dinner will be at 9 p.m. Dancing, which will be to Arthur Salisbury's Band and a modern group, will end at 2.0 a.m. Tickets are 5 guineas for qualified members, and 4½ guineas for students. Tickets can be obtained from the Chairman.

NOEL JAMES, Chairman, Ball Committee.

Art Society Exhibition

At the end of this term the Art Society plan to hold a Spring Exhibition, which is to extend from 7th to 19th March, and to which all members of the Hospital, both staff and students, are cordially invited to submit paintings, drawings, items of sculpture, etc.

Those interested are asked to contact the Secretary of the Society via the East Wing Lodge. He will be glad to provide further information.

The first meeting of the term will be on Thursday, 3rd February, at 5.30 p.m., in the Physiology Theatre, when E. H. H. Archibald, Esq., Curator of Oil Paintings at the National Maritime Museum, Greenwich, will give an illustrated talk on the development of the Netherlands and British marine painting schools. All are welcome.

The Residents' Play

This year the Play will take place from February 21st to February 25th inclusive at 8 p.m. in the Physiology Lecture Theatre. Applications for tickets should be addressed to the President of the Residents, c/o East Wing, and should be received not later than February 15th. Any donations towards the cost of production will be gratefully accepted.

Tickets will not be required for the dress rehearsal on Sunday, February 20th, to which students and nurses are invited.

Annual Dental Clinical Meeting

The Annual Dental Clinical Meeting will be held in the Dental Department on Saturday, 5th March, 1966, and the Dental Society Dinner will be held in the evening. A resumé of the programme will be published in the *Gazette* on the 19th February, 1966.

Guy's Hospital Science Club

The next meeting of the Science Club will be held in the Committee Room in the Medical School on Wednesday, 2nd February, at 4.45 p.m.

Professor R. A. Gregory, F.R.S., will speak on "Nervous and hormonal control of gastric secretion." The Chair will be taken by Professor J. N. Hunt.

Tea will be served at 4.30 p.m. in the Staff Common Room. A cordial invitation is extended to all members of the teaching and research staff of the Hospital and Medical and Dental Schools.

J. N. CROSSLEY, Hon. Secretary.

CORRESPONDENCE

More About Towne

SIR,—In your issue of the 8th January, two of your readers expressed dismay at the possibility of the disposal of Joseph Towne's collection of wax models now in the Gordon Museum. As your own editorial comment pointed out, the sources of that information in the Medical Press are inaccurate. I am sure that the gentlemen concerned will feel reassured by your remarks. They may also be assured, together with any others who have been similiarly misled, that in so far as anatomical models are concerned, any proposal which may involve their loss to this School would be most strongly opposed by the teachers of the Department of Anatomy here. Although opinions may vary as to the teaching value of Towne's superb anatomical models, their historical value is so great that their loss cannot be countenanced. It is unfortunate that some misguided person has spread unfounded rumours.

Yours, etc.,

ROGER WARWICK.

Anatomy Department,
Guy's Hospital Medical School,
London Bridge, S.E.1.

Brought to Book

SIR,—Although the Wills Library staff were pleased with your mention of the late opening arrangements in Passim, I feel that the phrase "although occasionally not running smoothly" needs a little clarification. In fairness to the library staff and to the student librarians, I feel that it should be pointed out that the occasional rough passages have been due to an irresponsible minority of students who have either arrived late or not at all or who have sent messages at 5.30 to say they could not come on duty that evening. To the best of my knowledge on one occasion only has the library closed because of this. On a number of occasions it has been touch and go and the service has been carried on with the help of volunteers and pressed men (including two registrars on one occasion.)

Yours, etc.,

WILLIAM HILL.

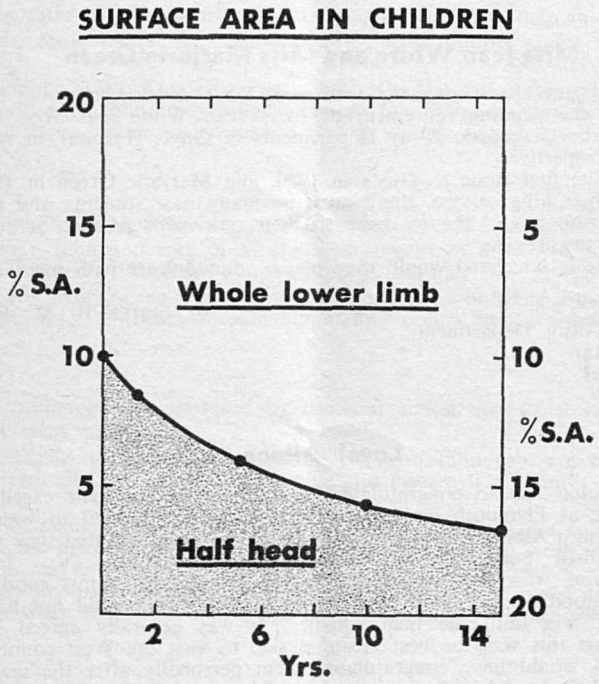
The Wills Library,
Guy's Hospital.

The Burnt Child

SIR,—I enjoyed reading the article by Mr. D. J. Richards on "Burns in Childhood" (*Gazette*, December 11th, 1965). I would like to emphasise three points:

(1) The take-in paediatric students take a very active part in the care of the burnt child. This includes carrying out some of the laboratory procedures, many of which need to be repeated at frequent intervals; they are also responsible for the graphic plotting of the clinical, haematological, and biochemical progress of the patient, to which Mr. Richards referred.

(2) The assessment of the percentage of body surface burnt at different ages has been made easier by the adoption of a chart suggested by Dr. N. O'Doherty (see Fig.)



Through childhood the combined surface area of one whole lower limb and half of the head is 20%, the contribution of each varying inversely. For other areas the "rule of nines" applies throughout.

(3) Nowhere is comprehensive management of the patient better exemplified than in the care of the burnt child. Thus, although the management is under the combined care of a surgeon and a paediatrician, it is not at all unusual for many other skills, such as renal, psychiatric, ear, nose and throat, etc., to be called in for advice.

Yours, etc.,

M. C. JOSEPH.

Department of Paediatrics,
Guy's Hospital,
London, S.E.1.

Dr. Gordon Thomas

SIR,—Many students and others will remember the late Dr. Gordon Thomas, who taught histology in this department for a considerable number of years. His death, approximately a year ago, deprived us of a most valuable teacher and colleague whose ever readiness to help went far beyond this department. Dr. Thomas's many friends will be delighted to learn that an anonymous gift of £1,000 has been donated to the School in his memory, to be devoted to such purposes in the Department of Anatomy as Dr. Thomas himself would have wished. I am sure that many of your readers will join me in offering warmest thanks for his generosity to the donor.

Yours, etc.,

ROGER WARWICK.

Anatomy Department,
Guy's Hospital, Medical School,
London Bridge, S.E.1.

Miss Jean White and Miss Marjorie Green

SIR,—I feel sure there are many readers of the *Gazette* who would be interested in the pending retirement of Miss Jean White and Miss Marjorie Green from the Diagnostic X-ray Departments of Guy's Hospital, in April and May, 1966, respectively.

Jean White first came to Guy's in 1930, and Marjorie Green in 1925, and because of their long service, there must be many past students and members of the staff who might like to come to their retirement parties, or contribute to their retirement gifts.

If anyone is interested would they please communicate with me.

Yours, etc.,

SISTER B. M. RANDLES.

Diagnostic X-Ray Department,
Guy's Hospital,
London, S.E.1.

Loyal Albion

SIR,—I should like to congratulate the Rugby Club on their excellent performance at Plymouth on Saturday, January 8th. I went to watch them against Plymouth Albion mostly out of loyalty and was afraid that they might be severely troubled. Such was by no means the case.

The Albion, who have scored 400 points this season against good opposition, got as good as they gave in every department, and could not have been sure of their win until the final whistle. It was generally agreed by their supporters that this was the best Hospital side to visit the West country for a long time. I would have congratulated them personally after the match, but feared that their beer-drinking propensity might equal their enthusiasm on the field.

Yours, etc.,

W. J. M. HALE.

Stentaway Cottage,
Stentaway Road,
Plymstock,
Plymouth.

ANSWERS

(Answers to "Some Questions and Answers" — page 37)

Series A.

Q.1. The units employed in modern clinical practice are:—grammes of haemoglobin per 100 ml. blood. Haemoglobin percentage depends upon an arbitrary standard and should no longer be used.

Q.2. No.

Q.3. Red cell mass is currently measured in ml. R.B.C. per kilogram body weight, but more usefully expressed in relation to lean body mass.

Q.4. Either the haemolysing tissues such as the spleen are abnormal in uraemic patients or their plasma is abnormal.

Q.5. Incubation of normal cells in uraemic plasma increases haemolysis.

Series B.

Q.6. The ratio of cells to plasma in the capillaries is less than in the veins.

Q.7. Yes, some hours may elapse before haemodilution causes a fall in the haematocrit.

Q.8. 4 litres. Slowing may have occurred in the circulation rate of the red cells, and the ratio of total body haematocrit to the peripheral venous haematocrit may be changed before an increase in plasma volume occurs.

Q.9. 36%.

Series C.

Q.10. These conditions are currently classified as collagen disease.

Q.11. No. Increased rate of synthesis is sometimes offset by increased catabolism even when the serum concentration is normal.

Q.12. Cells synthesising y-globulins in response to antigens either exogenous or endogenous. Synthesis presumably mainly occurs in the fixed lymphocytic tissues.

Series D.

Q.13. Urobilinogen is produced by bacterial action, in fact from bilirubin.

Q.14. A weak acid.

Q.15. Salicylic acid and phenobarbital, like urobilinogen, are excreted most rapidly in an alkaline urine, amphetamine and mecamylamine most rapidly in an acid urine.

Q.16. These substances in the uncharged (unionised) state are soluble in lipids and can pass through cell membranes. In alkaline solution weak acids are fully ionised, in acid solution weak bases are fully ionised. Charged (ionised) particles do not readily pass through cell membranes. Thus weak bases are trapped in the urine when it is acid, and weak acids are trapped in the urine when it is alkaline.

REVIEWS

" RADIOLOGY."

For General Practitioners and Medical Students, by David Sutton. Published by E. & S. Livingstone, Ltd. *Price* 12*s.* 6*d.*

A liberally illustrated little manual that is extremely easy to read. It covers briefly the major part of modern radiological practice describing techniques and findings in a remarkably concise way. I think it has no rival in its price range, and it would be a valuable addition to any clinical students' book list. If it has faults they are due only to the effects of over-condensation, which have made the referential extraction of information inevitably rather difficult, but as this is not what the book is basically designed for, I have no hesitation in thoroughly recommending it.

M. F. D'SOUZA.

"A SIMPLE EXPLANATION. VENEREAL DISEASE",

by Philip S. Silver (1965). 2s.

This pamphlet concerns itself not so much with venereal disorders as a whole, as with syphilis and gonorrhoea, and has been written for a wide, mainly non-medical audience. It is a clear and careful exposition; yet one wonders what rôle this medical pamphlet is expected to play, since the information can be gathered from text-books, readily available in libraries, or from the Encyclopaedia Britannica. If it is a matter of drawing these disorders to the attention of the public, then of course, this is one way of doing it.

A. S. Grimble.

LECTURE NOTES ON GENERAL SURGERY,

Harold Ellis and Roy Yorke Calne, Blackwell Scientific Publications. 382 pages. *Price* 42*s*.

" . . . Unfortunately few men are perfect, and most approach the qualifying examinations depressed by the thought of the thousands of pages of excellent and exhaustive textbooks wherein lies the wisdom required of them by the examiners."

Such is the authors' understanding of the perennial problem facing prospective examinees. Medical students will warm to the sentiment as they will undoubtedly warm to this book.

In 382 pages it is obviously impossible to provide the be all and end all of surgical instruction; thus the work cannot boast a single photograph and has only some 35 illustrations. In addition it omits sections covering ophthalmology, E.N.T. and orthopaedics. Neither does it give any details of surgical technique. But it is packed with useful classifications and summaries, being particularly good on head injuries, whilst managing at the same time to be fluent and easy to read. In this respect its title "Lecture notes on—" is a misnomer.

Although principally written for the use of final year students, as a means whereby they may clarify and regiment knowledge already acquired rather than learn anything new, the book must inevitably find wider appeal. It will admirably serve to provide the Junior Surgical Dresser with a sound framework on which to hang his clinical experiences and at the same time will be of inestimable service to him when he comes to read the standard surgical works. In short, a thoroughly workmanlike book and well worth 42s.

ORTHODONTIC DIAGNOSIS

by J. S. Beresford, B.D.S., F.D.S., D.Orth. Bristol. John Wright & Sons, Ltd. 1965. *Price* 13*s*. 6*d*.

This is the fourth title in the paperback "Dental Practitioner Handbook" Series, which aims to provide a concise, up-to-date account of a particular field of dentistry for both practitioners and students.

This book sets out to describe and classify malocclusion, and to bring out the basic principles upon which treatment may be planned.

There is a brief description of the clinical examination of a patient, but no detail is given of the type of radiographs that may be used to reveal unerupted teeth and solve such common problems as the localisation of maxillary canines and supernumeraries.

Angle's Classification and Ballard's Skeletal Classification are dealt with in some detail, and a chapter on the soft tissues describes their morphology and behaviour in relation to various classes of malocclusion.

There is an account of the shape posture and movements of the mandible and an excellent final chapter on planned dental extractions in orthodontic treatment.

This book is well produced and clearly illustrated. It achieves its purpose in covering effectively one important aspect of orthodontics. It is clearly not intended to compete with the more comprehensive and expensive textbooks required by the dental undergraduate, but does provide a valuable and readable account of the modern view of orthodontic diagnosis.

J. K. Luffingham.

A TEXTBOOK OF HUMAN EMBRYOLOGY.

by R. G. Harrison, M.A., D.M. Blackwell Scientific Publications, Oxford. Pp. 248. *Price* 47*s*. 6*d*.

The use of diagrammatic representation in describing embryonic ontogeny, while recognised by many as essential in illustrating textbooks and lectures on the subject, is still insufficiently exploited in either case. *A Textbook of Human Embryology,* aimed at the 2nd M.B. student, certainly enhances its value in the usage of line drawings as well as photomicrographs in trying to present a visual description of the anatomical changes that take place. But there is still room for improvement, especially in the chapter on the Urogenital System—a difficult system for the student imagining its chronological changes at the best of times.

In this very readable book, the author approaches the subject from a functional point of view rather than topographically, and assumes a moderate foreknowledge on the part of the reader. Through this assumption one of the purposes of the study of embryology, that is, the understanding and knowledge of adult anatomy *from* a study of its development, is lost; a fault of most teachers and writers on the subject. The book ends with a short chapter on regeneration and lists the different congenital abnormalities that can occur, at the end of each appropriate chapter.

COLIN B. BROWN.

A NEW LOOK AT ANAESTHETICS.

by J. Parkhouse. Pitman Medical. 88 pp. *Price* 7s. 6d.

This is the fifth title in the New Look series: it is not a textbook.

The author takes a long look at the past, present and future of anaesthetics as a speciality, with particular reference to postgraduate education. He emphasises throughout that the views expressed are personal, and often Utopian in conception.

Dr. Parkhouse's plan consists of four years organised, basic postgraduate training with little clinical responsibility. At the end of this period the anaesthetist would be of the standard, academically, of to-day's senior registrar: he would then begin a period of "clinical apprenticeship" leading up to full responsibility. The first four years would be spent in a university environment, and the clinical apprenticeship period would largely take place in regional centres.

The author suggests five-yearly reviews of all consultant posts, enters a plea against early and amateur specialisation, and abhors the use of travel, research and publication merely as status symbols.

The book will be of interest to anyone who is contemplating anaesthetics as a career, but it is directed primarily towards those responsible for training anaesthetists. The style is easy to read and the subject matter can be covered in an evening.

P. A. D. WILLIAMS.

ELEMENTARY BACTERIOLOGY AND IMMUNITY FOR NURSES.

Stanley Marshall. 4th edition. Published by H. K. Lewis at 12*s*. 6*d*.

This is a new edition of an old favourite. The matter is well explained and there are useful summaries at the end of each chapter. It would be helpful to have more information about routine vaccination and immunisation; for example, polio vaccine is not mentioned. Also, the tables of "spread of infection", etc., are rather difficult to read as they are in small type. These points apart, the book is a useful one for nurses and cheap enough for them to be able to purchase it.

B.B.W.

SURGERY IN THE MAKING,

By Gordon Murray, M.B., F.R.C.S. (Eng.), F.R.C.S. (Canada). Pp. 236. 7 illustrations. Johnson Pallealus Ltd. London. 1964.

This is both an autobiography and a review of surgery over the last thirty years, written mainly for the lay public. It is attractively written and the style is reminiscent of the books on medicine written before the war by " Harpole." Each chapter has a point, yet one can follow through this story the progress of surgery and Mr. Murray's distinguished career over the years. It makes an interesting chronicle.

J. C. GAZET.

THE OPERATIONS OF SURGERY,

by A. J. Gardham, M.S., F.R.C.S., and D. R. Davies, M.B., F.R.C.S, of the University Hospital, London. 9¾in. x 7¼in. Pp. 664 + viii Illustrated. 1963. London. J. & A. Churchill, Ltd. *Price* £5 0s. 0d.

It was most interesting to read this book, which is a successor to the original work of Jacobson, later edited by Rowlands and Turner; all late members of the Surgical Staff at Guy's.

The first volume covers infections and injuries of the soft tissues, burns and plastic surgery, surgery of the breast and lymphatic gland, surgery of the abdomen and genito-urinary surgery.

The style is direct, the teaching didactic, illustrated with 389 drawings. Indications and techniques are clearly set out in each chapter and only established procedures are described.

This book can be recommended as a safe basis on which to found one's surgical practice.

J. C. GAZET.

A DENTAL PRACTITIONER'S HANDBOOK, NO. 1.

"SILVER AMALGAM IN CLINICAL PRACTICE."

by I. D. Gainsford. Bristol. John Wright and Sons Limited, 1965. Pp. 79. 79 illustrations. *Price* 13*s*. 6*d*.

This handbook is the first of a series of books designed to present an authoritative appraisal of the current trends in various aspects of the practice of dentistry. The contents will appeal to both the undergraduate and post-graduate students and makes a most welcome addition to the literature concerning a material which is frequently used and misused and is often underrated.

The publication is written concisely, and is provided with numerous illustrations to portray various features of the subject which include cavity preparation, linings, matrices and manipulation of silver amalgam. However, not all these diagrammatical components are condoned in the text. For example, many of the cavity outlines (delineated in the chapter on cavity preparation) show sharp line angles or sharp point angles, although the author includes a brief paragraph explaining that these are not desirable. He mentions that experiments involving photo-elastic stress analyses of amalgam cavities have shown that rounded line angles produce less stress concentrations than do sharp line angles. Perhaps this section could have been extended to advantage, and recent work by Granath (1963 and 1964) used to illustrate the necessary advantages to both the restorations and the remaining tooth substance.

For those interested in paedodontics it may come as a surprise that no reference has been made to the use of silver amalgam in restoring the deciduous dentition. Special consideration should be given to cavity design, care of the pulp and adaption of the filling material and the inherent differences in technique required for deciduous teeth may be overlooked, even by those particularly interested in the subject.

It is possible to discern two spelling errors which often give rise to misconceptions on the part of dental students. On pages 49 and 52, the matrix band "SIQVELAND" is produced as "SIQUELAND" and on page 67 George M. Hollenback is referred to as "Hollenbach".

A photograph on page 53 depicts a series of metal bands which the author suggests can remain on the tooth until the amalgam has become sufficiently strong to be left unsupported. If, in fact, the bands illustrated under heading "B" are aluminium, as the title states, then the wet amalgam will not be supported for very long. As many operators and patients have discovered unexpectedly, the free mercury in contact with the aluminium produces a proliferative growth of aluminium oxide accompanied by the production of a considerable amount of heat.

In conclusion, it must be said that the author is to be complimented on presenting an everyday subject in such an interesting and informative manner. It is not difficult to predict that practitioners and students alike should find this book a valuable aid in endeavours to produce good amalgam restorations.

D. LONDON

PHARMACOLOGY

by J. H. Gaddum.

To the average medical student (i.e. those who do not ask questions at mid-day when it's lunch time, or at 10.30 p.m. on "take-in"), Pharmacology is an unfortunate adjunct to his studies. One's first contact with this subject is extremely bewildering—many incomprehensible "foreign-sounding" words such as adrenergic, cholinergic, muscarine (full of Eastern promise, no doubt), etc., etc. Later come tedious experiments where poor little mice are put to sleep and the dose which sends 50 per cent of them off (by which time 90 per cent of medical students have gone, those remaining being the questioning ones) is of more importance—one is not quite sure of what importance but at least of some. Then those chemical symbols, which one thought one had finished with, meaningful only to the initiated. Was it meant to be exciting when a $-CH_3$ group was changed from the 17 to the 11 position on those fairy rings and thus changed the property of the compound? No, Pharmacology has become the concern, so it appears, of the researchers and the experimenters.

An Introduction to Pharmacology—a slim volume of 1,048 pages—so we are told in the Foreword "can be expected to meet the needs of science students studying experimental pharmacology, and it will be invaluable to medical and veterinary students bridging the gap between pre-clinical and clinical studies". The former statement I am sure is true, but the latter, never.

MATHEW LEWIS

PREVENTIVE MEDICINE FOR NURSES AND SOCIAL WORKERS

by J. B. Meredith Davies. E.U.P. *Price*: Paperback, 8*s*. 6*d*.; Boards, 15*s*.

This book covers a wide range of topics, starting with chapters on the structure of the Health Service and the measurement of Health, it deals with all stages of preventive medicine from cradle to old age. The final chapters are concerned with international problems, health education and a brief glimpse into future trends in preventive medicine.

There are some omissions, the section on Venereal disease seems sketchy and there is very little reference to Family Planning, surely a world problem? Of course, in a book of this kind where so much information is given on such a wide range of topics, the text can never be complete, but its value would be greatly increased if lists of pamphlets for reference or books for further reading were added at the end of each chapter.

These points apart, it is a pleasure to be able to recommend a book so unreservedly. This could well become the "standard" textbook for nurses on Communal Health, which is such an important part of the new syllabus. It should not only be in the possession of every nurse but is cheap enough for her to afford it.

TABER'S CYCLOPEDIC MEDICAL DICTIONARY.

Blackwell. 10th Edition. *Price* 54*s*.

This American medical dictionary has passed through many editions, and has established a place for itself, at least, across the Atlantic. Because of its very nature it would be of more advantage to buy the British equivalent, but even this must be periodically replaced to keep up-to-date, and for this reason it is really a book for departmental bookshelves or libraries.

Taber's book is well produced and authoritative and much care has been taken to be precise in definition. Most subjects listed are treated both as differential diagnosis and text book stuff. Although it is a good book, it can have no place in the medical student's list of books-to-buy.

P. BOWDEN.

SPORT

For the first time in recent years, Guy's have been obliged to appear in the first round of the Hospitals' Rugby Cup Tournament. This can only be considered fortunate, for it provided a much needed opportunity for the team to develop confidence in both itself and the hospital at large. Both these aims were admirably met when Guy's played St. George's and won handsomely 33—6, scoring nine tries in all, seven of them on the wings. St. George's must be complimented, however, on a very spirited opening twenty minutes, when sheer determination stole the honours from the far more talented but slow starting Guy's pack. Two obvious lessons emerge. The forwards must get "stuck in" first, and the scoring potential of our wings must be exploited to the full. If Guy's can achieve and maintain both throughout the competition, then the mounting confidence of the side, now rivalling that of the "A" XV in their bid to retain the Junior Cup, will surely prove well justified.

On the Saturday preceding the cup match, the 1st XV travelled to Plymouth and gave the exceptionally strong local side their best game for some months, when they were defeated 10—0. Last Saturday, on the bitterly cold morning of the England-Wales international, Taunton were entertained at H.O.P. on a ground that resembled concrete and had the added comfort of being slippery. Tackles consequently may be described as high and reluctant, and the falling on loose balls defies description since little, if any, was seen. Considering the extreme conditions, however, the performance of both sides was very creditable, and Taunton, taking more use of the few opportunities offered, scraped home 8—3.

DIARY

Jan. 22.—Rugby Football v. Devonport Services. At home.
Hockey v. Tulse Hill II. Away.
,, 25.—Rugby Football. 2nd Round Hospitals Cup v. The London. At Bart's.
Squash v. St. Thomas's. Away.
,, 26.—Association Football v. The London. At home.
,, 27.—Squash v. Wimbledon "A." At home.
,, 29.—Rugby Football v. Old Millhillians. Away.
Hockey v. N.P. Bank. At home.
Association Football v. St. Mary's College. Away.
Feb. 1.—Squash v. West London S.R.C. (Cumberland Cup). At home.
,, 2.—Association Football v. Westminster Hospital. Away.

REPORTS & RESULTS

RUGBY

GUY'S v. RICHMOND

At H.O.P. Saturday, January 1st, 1966
Result: lost 0—11

In one of the best exhibitions of rugby seen at Honor Oak Park for some time, Richmond won a hard, open game by one goal and two penalties to nil. Few mistakes were seen and many fine movements took place after loose scrums which were well controlled by the two hard-working and well-organised packs. With a strong wind behind them, Richmond took command during the first half, but it was to Guy's credit that the second half saw the Hospital side gaining control. The final penetration was lacking, however, and we had to be content with holding the strong Richmond side to eleven points.

In the first twenty minutes the opposition showed their determination, particularly in forward play, with rapid interpassing movements and complete control of the short ball in the line-outs, this culminating in a try halfway out which was duly converted by Allan, an accomplished full-back. Further scores were only prevented by hard tackling, determined fielding and rapid scrumming over the loose ball. Guy's had learnt the lesson by this time and began to bind in the line-outs, control the short ball and, in addition, started to gain possession in the loose. We then saw both sides start to use the threequarters, and play moved rapidly up and down the field with superb interpassing among the backs, particularly by Richmond. Guy's looked most dangerous after gaining possession from the loose and when using the grubber or short kick ahead. The tight scrums were evenly balanced, and quick and effective tackling prevented either side from breaking clean through after the set movements. A hard but fractionally late tackle gave Richmond a penalty which was converted to push their lead to eight points.

With the wind behind them, Guy's had territorial advantage in the second half. Richmond changed their tactics in the line-outs and used the long throw with very effective peeling off around the back, but overall possession was about equally shared. The Hospital could not break through, although they came close to it, especially when following up kicks ahead, and

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after gaining possession in the loose. Both wings had the ball but not quickly enough to avoid the covering Richmond defence, and we did not see methods of attack such as the wings coming in between scrum and fly-half, or the scissors, being attempted. However, it was a day for fitness, good interpassing, hard tackling and open rugby, and Richmond won because they were slightly faster and more successful in their kicking. Their second penalty followed a line-out infringement to give them the game 11—0.

With the Hospitals' Cup approaching, it was encouraging to see the Guy's side relentless in their determination to gain supremacy in this hard match. No one let the side down. Elliott made up for two unsuccessful penalty attempts from some way out by a very sound performance at full-back; Cockburn celebrated his return to the side with a powerful forward game, and Morgan gave us a taste of his potential on the wing.

S. A. R. COOKE

GUY'S v. PLYMOUTH ALBION

At Plymouth Saturday, January 8th, 1966
Result: lost 0—10

This year Guy's travelled down to the West Country to meet the strong Plymouth side who have lost only twice this season: once to Leicester, and once to Capt. Crawshay's team which contained ten internationals. Albion's strength lies in their heavy and experienced pack, so it was Guy's intention to play an open game and try to outplay and outlast Plymouth in the loose.

Plymouth kicked off, and the opening exchanges took place in the Guy's half. The Plymouth pack got plenty of the ball from the set scrums and the line-outs, and Guy's line was immediately under pressure. However, the Guy's defence held firm, and with the aid of Swift's long, accurate kicks for touch, Plymouth's attacks were resisted. But, Guy's gave away several penalties in their own half, and if Plymouth had possessed a competent place-kicker, they could have taken the lead.

About half-way through the first half Guy's began attacking themselves and soon produced the best rugby of the game. From a line-out Guy's gained clear possession and the ball went down the line to Morgan who gained twenty yards with a fine run down the left wing. Soon after this effort, Guy's took a short penalty on their own ten-yard line. The ball went to Lindsey who drew his man and put Ross away on the right wing with a perfectly timed pass. Ross beat several men in a run of forty yards or so and was only stopped a few feet short of the Plymouth line. The Albion full-back was knocked out in his heroic tackle to stop Ross and had to leave the field to recover. The ensuing scrum, near the Plymouth line, nearly resulted in a try for Guy's when Williams, who had a good game, caught Albion's scrum-half in possession, but the ball could not be touched down.

The closing minutes of the first half saw exciting play from both sides. The Guy's pack were doing well to hold their own and supplied the threequarters with a liberal amount of loose-heads. The threequarters in their turn were not wasting their opportunities, and supported by the back row, always looked capable of scoring.

Guy's kicked off in the second half, and any hope harboured by Guy's that the Albion pack would tire were quickly dispelled. In fact, Plymouth encamped in the Guy's half to exert constant and increasing pressure so that Guy's were soon desperately defending their own line. Attack after attack was launched and it was inevitable that Plymouth would score, and score they did. They healed from a loose maul near the Guy's line and a wing-forward forced his way through to score. The try was converted.

This pattern of play continued and Plymouth eventually scored again. This time they heeled from a set-scrum and the heavy Albion centre took the ball at speed and crashed over to touch down. This try was also converted. Nevertheless, in the last quarter Guy's took the play back to the Plymouth half, and movements in which Elliott, Edgar and Williams were often prominent produced an exciting close to the game.

Guy's should be well pleased with their performance—everyone had played well, and they had played as a team. Plymouth supporters agreed afterwards that Guy's had played the best rugby seen there for many months. They were delighted that the Albion, after several easy wins, had been so extended by the Hospital side. This form, if reproduced by Guy's in Hospital Cup matches, should bring the Cup back to its rightful home!

Guy's Team: D. Elliott; J. Ross, M. Lindsey, J. Edgar, I. Morgan; B. Rowlands, P. Swift; J. Davies (Capt.), G. Hey, R. Stansfield, A. Kingdon, P. Peace, H. Sharp, J. Cockburn, P. Williams.

J. C. CRISP

1st Round Hospitals' Cup
GUY'S v. ST. GEORGE'S

At Herne Hill Tuesday, January 11th, 1966
Result: won 33—6

On a very cold, windy day, Guy's kicked off with the wind, after both sides had agreed to play on a pitch hardened by recent frost. Guy's were expected to win this match, but as so often happens the underdogs, with everything to gain and nothing to lose, were full of enthusiasm and settled more quickly. However, as soon as Guy's got into their stride it was obvious that they were superior to St. George's in all aspects of the game, and after eight minutes Ross scored the first of his three tries, beating his man on the outside and scoring in the corner. Elliott converted with a very fine kick. Before half-time Guy's had plenty of possession and many chances to score, but could manage only one more try, by Morgan, on the left-wing, who scored in the corner after a fine run.

Sensibly the referee allowed only a couple of minutes for half-time in such cold weather, and it was not long before Guy's began to make better use of their chances, and playing to their strength, Ross and Morgan on the wings, tries came at regular intervals throughout the second half. Ross scored two, Morgan three, and Edgar and Davies one each in this second half. Elliott converted only two of these, but it must be added that he was kicking against a very strong, blustery wind.

During this second half, attention was temporarily drawn away from the match when the St. George's mascot, a wooden cockerel, painted patriotically in the colours of its owners, inevitably changed hands. It is rumoured it may be returned with a suitable change of paint.

As far as the match was concerned, with so much possession it was not surprising that Guy's should make a few mistakes, from two of which St. George's scored tries. However, this was a good performance by Guy's. In particular, Ross and Morgan played very well on the wings, making the most of their speed. Of the remainder Thorburn made two superb breaks from the scrum which demonstrated his exceptional class, and everyone played well within themselves to gain such a big win. This augurs well for the next Cup match against The London on January 25th, when one can only hope the weather will be kinder than at Herne Hill, so that a larger crowd can be present.

G. E. RATCLIFFE

HOSPITAL INFORMATION

APPOINTMENTS VACANT

Applications are invited for the post of **Junior Lecturer in Chemical Pathology.** Salary £1,350 rising by annual increments of £85 to £1,690, plus £60 London allowance. Applicants should be medically qualified. The work will concern either protein metabolism or immunochemistry, and facilities are available for study for higher degrees. Applications should be made before the **31st January** on a form obtainable from the Dean.

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PERSONAL

Miss MacManus thanks the many old Guy's friends who have remembered her this Christmas. She wishes them every happiness and blessing in 1966.

Part-time Receptionist required for busy General Practice in New Cross. Hours 9 a.m. to 1 p.m., or 4 p.m. to 6 p.m. Apply Dr. B. Pereira, 23, Clifton Rise, London, S.E.14. Tideway 5443

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Noel E. Maylon, B.D.S., L.D.S., R.C.S., and Violet Maylon, L.D.S., are now resident at Suite 502, The Colonnade, 131, Bloor Street West, Toronto 5, Ontario, Canada.

Dr. H. N. Garrus, to Aley Lodge, Over Stowey, near Bridgewater, Somerset. Tel: Nether Stowey 312.

Mrs. Arthur Franks, 9, Fairacre, Roehampton Lane, S.W.15. Tel: Prospect 8737.

BIRTHS

WOLFLE.—On December 2nd, 1965, at the Cardiff Maternity Hospital, to Eileen Elizabeth (née Davidson) and John Wolfle, a daughter, Catherine Mary, sister for Paul and Andrew

BARR.—To Alan and Margaret, on December 11th, 1965, at Nuffield House, a daughter, Abigail Margaret.

BLAKE.—On 25th September, 1965, at Bowers House, 16, Fourth Avenue, Havant, Hants, to Monica Lisa (née Hughes) and Marcus Blake, a son, Rupert Miles, brother for Lorna Jane.

TEDRE.—On 18th December, 1965, at R.A.F. Hospital, Cosford, to Angela (née Morris) S.R.N., and Alec Tedre, M.B., B.S., a daughter, Sarah Jane, a sister for Roger and Stephen.

BOSWELL.—On January 7th, at Balmuto, Combe Dron, Bath, to Joan (née White), wife of David R. Boswell, B.D.S., a daughter (Margaret Joan), a sister for Robert, Andrew and Katherine.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

MARRIAGE

The wedding is taking place on January 22nd, at Swansea, between Dr. George Rhys Davies, M.B., B.S.(London), M.R.C.S., L.R.C.P., and Judith A. Harries, S.R.N., S.C.M. (part one).

DEATH

HAYTER, Alice Agnes Warner—died on November 15th, 1965, following a severe illness, aged 77 years. Miss Hayter trained in the Guy's Hospital School of Nursing from 1912 to 1915.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2022

PASSIM

Vagrancy

Within a mile radius of Guy's are two favoured meeting-places of London's vagrants, the Elephant and Castle and Waterloo. Because of this close proximity to Guy's these people are frequent visitors to our casualty department. They present as social casualties rather than medical and, as such, a modern casualty department is unsuited to deal with these pathetic people. The casualty officer is faced with a problem of disposal and although there are hostels and institutions, these provide little more than shelter on certain strict conditions, and in no way do they represent an answer to the problem of vagrancy.

Many of the vagrants, as shown in a recent article in the *Lancet,* are alcohol addicts with severe personality disorders. Economically, they are a burden on society and what little money they receive is mostly absorbed by their addiction. Their very physical condition reflects an inadequacy in the Welfare State, which makes no specific provision for them. It unloads this unwanted problem on the charity of a few inadequate and over-worked organizations.

One voluntary organization, the Simon Community, has struggled for two and a half years to provide food and shelter and the possibility of rehabilitation for these social misfits. To some extent it has been trying to implement the recommendations made only last week in the *Lancet.* They do not, however, enforce withdrawal of alcohol from the addict as a condition for residence and help. They aim at supplying simple human kindness, understanding and contact as a foundation on which rehabilitation of these socially sick people may become possible. They have a house in Camden Town for this purpose and plans for others in the near future. However, although they have a growing national network of volunteers, their means and facilities can only deal with an insignificant proportion of what is a national problem.

The extent of the problem is as yet unknown but the country at present supports them through prisons, National Assistance, unemployment and sickness money and charity. None of these measures, except the last, are specifically designed to accommodate vagrancy, and even this state aid is not always easily obtained. It would be more efficient, therefore, if the problem was given a more specific approach.

It might be economically sound and certainly socially humane, to establish some form of residential "social hospitals" which would accept the inadequacies of these people and provide facilities for settlement and work on a community basis. The establishment of these homes would facilitate the relief of the vagrant from his addiction and wanderings, and the public from a problem which it prefers to ignore.

Contraception Conscious

Contraception continues to arouse controversy in the Medical Press. The two moot points most frequently raised being what methods should be used and who should use them. Current statistics on the four most effective techniques seem to indicate that the Pill, is clearly the best (from the point of view of safety), with an unwanted pregnanacy rate of only about 1.0 per hundred woman years. The intrauterine device is next with an average recorded pregnancy rate of 2.6 to 5 per hundred woman years. The male condom and the female cap trail far behind these with average failure rates, calculated in the same way, of 13.4 and 11.8 pregnancies, respectively. This issue is, of course, far broader than that of relative safety alone. With the Pill reaching the country's attention so soon after the thalidomide disaster and the I.U.C.D. inheriting the suspicion meted out to its predecessor, the Grafenberg ring, there is a note of considerable caution in the air, which, coupled with the many side effects inherent in these methods, make the choice far from straightforward.

Notwithstanding these difficulties, however, the broader social question of who should use contraceptives has gained renewed attention recently, by the proposed opening of a new Birth Control Clinic in Sheffield whose publicly announced policy is to provide a contraceptive service for all persons over eighteen, irrespective of their marital status. That such a policy might be taken a step further was suggested in a recent letter to the B.M.J. by Dr. M. C. Latham, of Harvard. After making the interesting and initial observation that the I.U.C.D. differs from all other forms of contraception in the important positive aspect that it is removed in order that pregnancy can take place, as opposed to the other techniques which require continuous slavish employment to prevent conception. He went on to suggest that all girls of child-bearing age might be fitted with such a device by their school doctors, enabling the entire future population to be carefully planned, with exception, of course, of those unwanted pregnancies incurred by the failure of the method.

Such radical suggestions, although perhaps somewhat premature in this country, do raise ethical questions that the medical profession seems reluctant to discuss in any depth. But this is a field which we cannot simply refer to specialists, and if we are not careful we may find ourselves resolving more and more of our moral issues by considerations of pure expediency.

The Gazette, this week, is commencing a new section on Nursing News, beginning with a report on the Sisters' Christmas dinner. It is hoped that this innovation will help to make the *Gazette* more representative of every section of the Guy's community.

Mr. O. H. Shaheen has been appointed consultant E.N.T. surgeon replacing Mr. Cann, who retired on February 1st.

Mr. D. M. Watson has been appointed consultant ophthalmologist.

Professor D. J. Anderson has been appointed Professor of Oral Biology at the University of Bristol, as from August 1st, 1966.

Versus The Nurses

An unexpected find made in the present excavations in the Nurses' Home was kindly deposited in the Gazette Office recently by Mr. Lawrie. It is a miniature cricket bat bearing a number of almost illegible signatures, two of which appear to be those of Dr. Michael Price, and Miss Marjorie Marriott. This instrument was awarded as a prize for a cricket match between the students and the nurses on June 10th, 1939, which the students won by four runs. How this prize ever found its way into the Nurses Home we shall not question. Perhaps the hopes of the *Gazette* sports correspondent in 1939 may yet be fulfilled. He wrote: "After the game a miniature bat, very kindly given by Mrs. Ryffel, was presented to the winning team. It is hoped that this bat will be contested for annually".

Repulsion

The chequered career of *Pulse* is at last becoming more regular and its voices more familiar. Indeed, among the victims of its recent flagellations are all students who express opinion on South Africa, the editors of *Sennet*, the Governors of the Hospital and Mr. George Brown. One fears from these brave attacks that its policy is either to destroy the hospital, the Medical School, the University and the Government, or itself.

Dr. J. R. Trounce has been appointed to the new chair of clinical pharmacology at Guy's as from January 1st.

GUY'S DIARY

FEBRUARY

7th	M.	1.00	Clinical Lecture. Dr. EVANS. "Malabsorption".
8th	Tu.	1.00	Clinical Lecture. Mr. ECHOFF. "Tube Pedicles".
10th	Th.	1.00	Clinical Lecture. Dr. CARNEGIE. "Anaesthetics and Analgesia in General Practice".
11th	Fr.	1.00	Clinical Lecture. Dr. MacLEAN. "The Use and Abuse of Diuretics".
11th	Fr.	2.15	Combined Round. Dr. MacLEAN and the South East Regional Board Physicians.
15th	Tu.	1.00	Clinical Lecture. Mr. BLACKBURN. "On Examiners and Examinations".
17th	Th.	5.00	Neurosurgical Round to be conducted by Mr. FALCONER in the Clinical Theatre.
17th	Th.	1.00	Physiology Lecture Theatre. Professor ESKO NIKKILA (Helsinki), on "Triglyceride Metabolism.. Effect of dietary carbohydrates and of diabetes".
22nd	Tu.	1.00	Clinical Lecture. Mr. CLARKSON. "Modern Mammoplasty".
22nd	Tu.	1.00	Clinical Lecture, to Dental Students. Professor W. J. TULLEY. "Dental Treatment for Children—the Present and the Future". Dental Theatre.
24th	Th.	1.00	Clinical Lecture. Mr. WASS. "Undescended Testicles".
25th	Fr.	1.00	Clinical Lecture. Dr. HILL.
25th	Fr.	1.00	Clinical Lecture to Dental Students. Mr. K. E. PRINGLE. "Orthodontic Treatments".
26th	Sat.	10.00	Clinico-Pathological Meeting in the Clinical Theatre.

IS IT SIGNIFICANT?

A Case for Statistics

Dr. R. W. R. Baker

Department of Chemical Pathology

The word "statistics" is probably ill-defined for many people. To some it is the apotheosis of a damned lie; to others it recalls the circumferential measurements of young women. In sober truth, the word is concerned with the logical study of probability, and such study is necessarily mathematical. To readers terrified by the mention of mathematics, let it be said at once that our present concern with statistics is purely that of the user of an appliance. We have here potentially a tool as useful as any to be found in a laboratory or workshop, and one which is seldom overworked. It costs nothing, requires no maintenance, occupies no space, and it never wears out. If the above remarks were descriptive of a car, not so many people would be so indifferent as not to learn to drive, yet this neglect is often only too apparent in the case of the statistical aids with which we are here concerned. Any tool or method can be misused and the more powerful the tool, the greater can be the consequence of misuse. Certainly statistical methods have been abused in the past and will be in the future, but this provides no argument against their proper use; certainly the danger of road accidents will never justify the abolition of mechanically powered vehicles.

The concept of statistics to be presented here is that of a battery of methods which enables the resolving power of the mind to be increased, just as the microscope aids the eye. Further, it is hoped to show that the application of statistical methods can make for efficiency and economy in experimental work at a cost in accuracy which is known and can be controlled.

In the biological and social sciences particularly, it is common knowledge that quantities which are of interest exhibit a noticeable departure from constancy. Consider the variations in blood-pressure found in a group of people, all in good health and of much the same age and build; or the incomes within any one trade. In a crude way, the variations characteristic of such quantities are generally recognised, and are usually given some measure by the quotation of a range. Even for this, a trace of statistical judgment must be used. Human yearning for neatly-parcelled facts commonly asserts itself, however, and a pathetic

faith in arithmetical means receives due homage while the existence of variation is often ignored. If a clearer picture is to be painted, then four things must be established. We must know qualitatively how the values are distributed over the "population" which was sampled, and how many (n) individual items were studied. Thirdly, a central value should be given, and lastly a measure of the spread must be offered. For the last, a commonly used unit is the standard deviation, written in brief as "S.D." or "s". The alternative use of Confidence Limits (see below) is also frequently found. The information required to describe any "population" of measurements can be written very concisely in a form of which, if the reader will accept for a moment some terms to be explained later, a sample may be presented boldly as:

"Distribution, approximately Gaussian (Binomial, etc.). ($n = 48$).

$\bar{x} = 119$ (units), S.D. = 15 (units)."

The three attributes of the population so defined and the value of n are all that are generally required for a precise description; the over-popular central value is only one of a trio.

When values are subject to scatter, the distribution pattern can take different forms, mostly well-recognised. Commonly occuring distributions are those named as Gaussian (or Normal), Binomial and Poisson, but only the first will be used for purposes of illustration. Values obtained by direct measurement may not always fall into one of these recognised patterns, but can sometimes be induced to conform by simple transposition. For example, the reciprocals or the logarithms of the measurements may be distributed in a standard way, while the means of a reasonably large number of small groups, each of say six items, almost certainly will be. The Normal distribution may be described by the use of a diagram (Fig. i): this shows that the values in a "population", assumed infinite in extent, are spread in such a way that half the "population" gives values lower than the average, with the other half, of course, having higher values, and the whole arrangement is symmetrical. Progressively smaller proportions of the whole possess values diverging by increasing amounts from the mean. In the diagram, the shaded portions each marked "$\frac{1}{2}$P" represent by their areas the proportions of the infinite "population" for which values respectively higher and lower than the mean by a stated amount (shown as $\pm u$ standard deviations) will be found. The whole area under the curve represents the whole population (P = 1·0) In general there are three central values for a distribution, the mean, the mode and the median. The arithmetical mean "$\bar{x}$" needs no explanation, but perhaps it should be mentioned that the mode is the most "popular" value, shown by the

highest proportion, while the median is the value such that the proportions of the "population" having values which are either higher or lower are the same i.e. $\frac{1}{2}$. In any symmetrical distribution, as in that taken here for an example, the three central values coincide. Also in Fig. i, a sketch of a Poisson distribution about the same mean is shown as a broken line with the central measures marked. This type of distribution describes radioactive decay, with the median as an expression of the half-life.

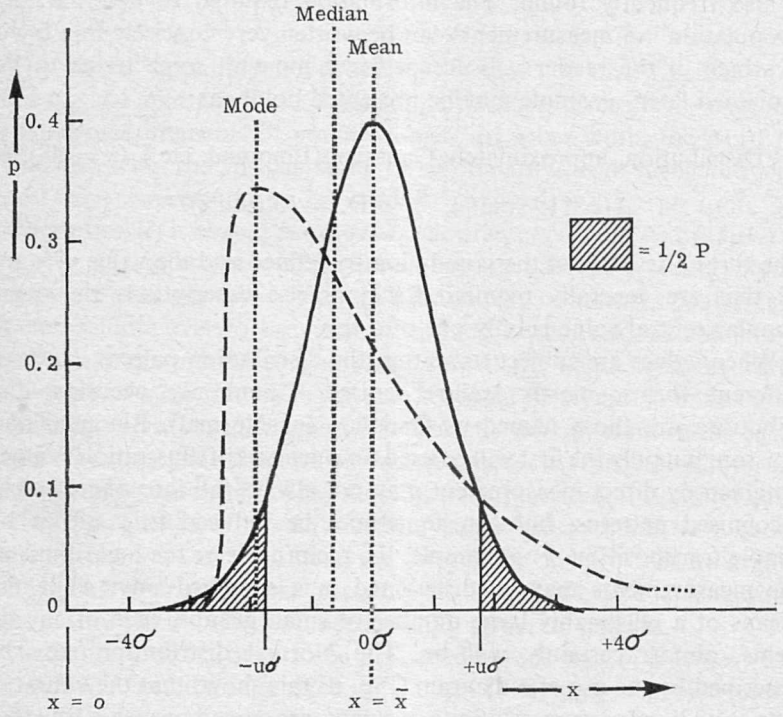


Fig. i. The Gaussian (or Normal) distribution (solid line) and a typical Poisson distribution (broken line). The scale of units for the variant x has not been marked but values corresponding to 0, 1, 2, 3, 4, and u standard deviations (σ) for the Gaussian distribution are shown P is the proportion of the "population" of measurements of x.

Any graph is the visual representation of a mathematical equation, and the Normal distribution described above in graphical form is more usefully defined in the latter terms, by the means of which its properties have been explored. As a result of such studies in the past, many useful results have been published in the form of tables and equations. Because of this, "populations" of measurements can readily be described and compared by purely arithmetical operations carried out by substituting values into standard algebraic expressions. Fortunately, the properties

of the Gaussian distribution still apply with sufficient accuracy for most purposes even when the distribution considered does not conform strictly to this pattern.

Formerly the tedium of computation provided good excuse for neglecting these potentialities, but nowadays for about £250 or less an electrically powered calculator can be purchased, and will indeed be found already in many laboratories. Nor need anybody be fearful of such machines, for school-children can learn to use them in literally a few minutes, as the writer's family can testify.

Consider the results of a great number of measurements (say about 1000, $= n$) of some quantity which is distributed, as is often the case, according to the Gaussian pattern. From the results we can obtain, by a short-cut method, a close estimate ($\bar{x}$) of the true mean (μ) which would be found from measurements of all existing cases. By finding the mean, s^2, of the squares $(\bar{x}-x_1)^2$, $(\bar{x}-x_2)^2$, $(\bar{x}-x_3)^2, \ldots$, etc., where $x_1, x_2, x_3, \ldots$, etc., are values from individual measurements, we obtain

$$s^2 = \frac{1}{n}[(\bar{x}-x_1)^2+(\bar{x}-x_2)^2+(\bar{x}-x_3)^2+\ldots],$$

which is more compactly written as

$$s^2 = \frac{1}{n} \cdot \Sigma(\bar{x}-x)^2.$$

Now s^2 is an approximation to σ^2, the value which s^2 would have if n were infinite, when also $\bar{x}$ would have the value μ. The quantities μ and σ^2 are characteristics of the population: σ^2 is called the "variance", and is a measure of the spread. The square-root of $\sigma^2 = \sigma$ is the "standard deviation". Since n can never in practice be infinite, we have to accept the estimate s in place of σ, just as $\bar{x}$ is accepted in place of μ, while s^2 has to be taken as the variance. In fact, if n is about 200 or less, then it is necessary to modify the equation defining s^2 to the form

$$s^2 = \frac{1}{(n-1)} \cdot \Sigma(\bar{x}-x)^2$$

which is more convenient for use if put into the equivalent form

$$s^2 = \frac{n\Sigma x^2-(\Sigma x)^2}{n(n-1)},$$

where

$$\Sigma x^2 = x_1^2+x_2^2+x_3^2+ \ \ldots \ x_n^2,$$

and

$$(\Sigma x)^2 = (x_1+x_3+ \ \ldots \ x_n)^2.$$

Again, as in working out $\bar{x}$, there are short-cut methods which allow the calculation of s^2 with little effort when n is inconveniently large.

When, for the hypothetical "population" we are considering, $\bar{x}$ and s are known, we can use the recorded properties of the Gaussian distribution in an interesting way to see what proportions of "abnormal" results are to be expected. Published tables show the proportions of the results which give values exceeding the arithmetical mean by different amounts, the standard amount being one standard deviation. If in the present case $\bar{x} = 119$, with $s = 15$, then to find what proportion of all possible samples would be expected to present results for x of 131 or more, it is necessary only to calculate the "deviate",

$$u = \frac{131-119}{15} = 0{\cdot}800$$

and to find the required proportions ($\frac{1}{2}$P) from the table, which gives, for $u = 0{\cdot}800$, $\frac{1}{2}\text{P} = 0{\cdot}2119$. This means that 21·19% of all samples exceed the mean by this amount, i.e. exceed 131. Since the distribution is symmetrical, another 21·19% of all samples give results which deviate from the mean towards lower values by the same fraction of a standard deviation, i.e. they would in the present case give values for x of 107 or less. Similarly, 2·28% of Normally distributed samples exceed the mean by $2s$ or more, while another 2·28% fall below it by at least the same amount. This gives a clue as to how departures from the expected pattern can be noticed. If it were found that a higher proportion of samples, say 7%, were found in the higher range (giving x greater than $x+2s$) instead of 2·28%, then the presence of "foreign" samples in the population could be suspected, but at the same time the method of selection of samples for testing should be examined for inadvertent bias.

Consider now the mean of our Gaussian distribution. It is obvious that if we make repeated estimations of this, each from a group of, say, 10 specimens, then we shall not get exactly the same result each time. The answers will indeed be subject to a Gaussian distribution about μ. If groups of 25 specimens were used, the scatter would be less; with groups of 3 it would be much greater. This not only demonstrates the truism that the greater the sample-size becomes the closer does $\bar{x}$ approximate to μ, but also it shows how the accuracy attained may be determined. The distribution of means from different-sized samples are all Gaussian about μ, but they differ in spread according to $1/\sqrt{n}$, the reciprocal of the square-root of the number of single specimens in the sample. The standard deviations of these distributions of means are called "standard errors of the mean", often shortened to "S.E.M." or "ε", and for a "population" with mean $\bar{x}$ and a standard deviation s,

$$(\text{S.E.M.})^2 = \frac{s^2}{n},$$

or, more conveniently,

$$(\text{S.E.M.})^2 = \frac{n\Sigma x^2 - (\Sigma x)^2}{n^2(n-1)}.$$

The "coefficient of variation" quoted in some texts is simply the S.E.M. expressed as a percentage of the mean.

Going back to our exemplary population for which $x = 119$, $s = 15$, but supposing that this result had been obtained from inspection of 25 (instead of 48) individual readings, it follows that now,

$$\text{S.E.M.} = \sqrt{(15^2/25)} = 3.$$

From the tables as before, it can be read that a deviate of 1·96 standard deviations of the mean, i.e. $1{\cdot}96 \times$ S.E.M. "cuts off" 2·50% of all samples. This means that out of all the estimates of the mean made from repeated sample-groups of 25 specimens apiece, 2·50% will give, on the average, a value for x exceeding $119 + 4{\cdot}88 = 123{\cdot}88$. Simultaneously, 2·50% will produce a result for x of less than $119 - 4{\cdot}88 = 114{\cdot}12$. Thus, 95% of the results will in general lie between 114·12 and 123·88; these outside values are called the 95% "confidence limits" and incidentally should be cut down to 114·1 and 123·9, or even to 114 and 124 to avoid delusions of accuracy. The range spanned by the 95% limits becomes narrower as n becomes greater, so if an estimate of s is available it is easy to work out a value for n for which the limits will be acceptable, thus avoiding unnecessary experimental work. In the present case it can be claimed that it is 95% certain that the true mean μ lies between 114 and 124, with the most probable value of 119.

So far we have described a "population" of measurements, qualitatively in the nature of its distribution, and quantitatively with estimates of the mean and of the standard deviation; we have further a knowledge of the certainty with which the mean is known. This is fundamental in establishing the nature of the "population" studied. More exciting is the comparison of "populations" which may not on casual inspection appear to differ at all. What would you make of two Normally distributed "populations" of measurements represented as:

$$(i) \quad x_1 = 3{\cdot}80, \qquad s_1 = 0{\cdot}42 \qquad (n_1 = 16),$$

$$(ii) \quad x_2 = 3{\cdot}48, \qquad s_2 = 0{\cdot}39 \qquad (n_2 = 15)?$$

The answer, not discernible to the untrained eye, is obtained by application of Student's t-test, named from the pseudonym under which it was first published, and from "t" for "times" (cf. deviate as so many *times* the standard deviation). This answer is that there is less than a 5%

chance that they do **not** differ, so the chances are more than 95% (odds of 19 to 20) that they do, as demonstrated by four or five minutes of automated arithmetic followed by reference to tables. In the terms generally used, the difference between the two means is significant at the level $P < 0{\cdot}05$. With this much established, it is often wasteful to continue experimental work to the point where the uncertainty of difference is 1 in 1,000, i.e. $P < 0{\cdot}001$, for which both n_1 and n_2 would have to be increased to about 40–45, representing nearly three times as much time and work.

It is worthwhile to elaborate a little on the t-test. Suppose we have two identical, Normally-distributed large populations, A and Z. If a sample of, say, five single specimens were taken from each, the laws of chance ensure that their means would not necessarily be the same. Let us imagine these means differ by an amount we can call *d*. Repeated comparison of successive pairs of such samples from A and Z would give a series of results for *d*: a few would be large, most would be small; some would be positive (A > Z) and some negative (A < Z). After exhaustive sampling, the sum of all the values for *d* would be zero, the positive and negative values cancelling out, for A and Z were postulated as identical. It will be found that *d* is distributed symmetrically about zero, and that the standard deviation (ε_d) of this distribution will depend on the standard deviations (ε_A and ε_Z) of the distributions of the means of the samples from A and Z which were compared. In mathematical terms, since variances are additive, $\varepsilon_d^2 = \varepsilon_A^2 + \varepsilon_Z^2$, and it will be observed that ε_A and ε_Z are the standard errors of the means for the samples from the "populations" A and Z.

As in the discussion of the Normal distribution above, the chance of finding a value for *d* which deviates from its mean value (which here from the postulate is zero) by any given number of standard deviations (ε_d) can be found from tables. If the mean value for *d* had been found to be, not zero, but 8 units while ε_d were found to be, say, 3·2 units, then the deviate of the mean found for *d* from zero is $t = 8/3{\cdot}2 = 2\frac{1}{2}$ times ε_d, for which P is about 0·016, representing only 16 chances in 1,000, if indeed A and Z were identical "populations". Therefore, if when comparing as above two other "populations" of measurements, B and Y, the same result was obtained, i.e. $t = 2\frac{1}{2}$ times ε_d it could be argued that this would happen only 16 times in 1,000 if the real mean value for *d* was indeed zero. It is more probable that the mean for *d* is **not** zero, i.e. that the populations really do differ in their means. In short, the difference of means is said to be significant, with $P < 0{\cdot}016$.

Ideally, the mean for *d* found after infinite comparisons equals $\mu_B - \mu_Y$ where μ represents a "true" mean. In reality we have to use an

estimate for d equated to $\bar{x}_B - \bar{x}_Y$, so that

$$t = \frac{\bar{x}_B - \bar{x}_Y}{\sqrt{(\varepsilon_B^2 + \varepsilon_Y^2)}}.$$

When the numbers of items handled are small or unequal, certain corrections for this must be applied, and the distributions of $\bar{x}_B - \bar{x}_Y$ follow patterns diverging from the Gaussian form, so special tables are used, but in principle the testing is still done by substituting experimental values into standard formulae and reading off the probability (P) that the result obtained could actually occur if the "populations" did **not** differ. The mysterious "t" is nothing but the analogue of "u", the measure of deviation in terms of the standard deviation as the unit.

It may be added for the curious that in general terms,

$$t = (\bar{x}_1 - \bar{x}_2)\sqrt{\left(\frac{1}{n_1(n_1-1)\varepsilon_1^2 + n_2(n_2-1)\varepsilon_2^2} \times \frac{n_1 n_2(n_1+n_2-2)}{n_1+n_2}\right)}$$

which, if $n_1 = n_2$, collapses to

$$t = \frac{\bar{x}_1 - \bar{x}_2}{\sqrt{(\varepsilon_1^2 + \varepsilon_2^2)}},$$

and to state that when seeking P in the tables for the t-distribution, the line of values applicable to $(n_1 + n_2 - 2)$ is used. The last term is known as the "number of degrees of freedom" (of choice), and it is often given the symbol ϕ or ν.

It is in the comparison of means as above that most interest is often centred, obscuring the fact that "populations" with almost the same mean can still differ significantly in another respect. If we have

(iii) $\bar{x}_1 = 3{\cdot}80, \quad s_1 = 0{\cdot}63 \quad (n_1 = 16),$

and

(iv) $\bar{x}_2 = 3{\cdot}62, \quad s_2 = 0{\cdot}39 \quad (n_2 = 15),$

then the means do not exhibit a significant difference, but the variances do, and again we have to make a distinction between the two populations. In this case the ratio of the variances, $s_1^2/s_2^2 = 2{\cdot}749$, and from other tables relating this ratio with $(n_1 - 1)$ and $(n_2 - 1)$ it can be read off that the variances, and hence the populations of which these are attributes, are significantly different at the level $P < 0{\cdot}05$, so there is only 1 chance in 20 that they do **not** differ. One of the most common abuses of statistical methods lies in forcing invalid tests for the significant difference of means in the face of a tacitly ignored (or unsuspected) significant difference of variances. In fact, allowance can easily be made for the disparity of variances when testing the difference of means, and as might be expected, the allowance involves the requirement of more

stringent conditions before significance of difference of means at any given level is admitted. For example, in the two "populations" represented as

$$\bar{x}_1 = 25, \qquad s_1 = 6 \qquad (n_1 = 5)$$

and

$$\bar{x}_2 = 20, \qquad s_2 = 9 \qquad (n_2 = 9),$$

the smallest difference of means which proves significant ($P < 0{\cdot}05$) if the effects of the variance ratio is neglected is 4·3, but when the proper allowance is made this is increased to 6·5; in this case the variances are certaintly significantly different ($P < 0{\cdot}01$). The effect of correction for variance ratio is greater for more marked departures of this ratio from unity, and when n_1 and n_2 are small or widely unequal.

In detail, the correction is applied by finding t with the short equation above (as when $n_1 = n_2$) and calculating a reduced number of degrees of freedom, ϕ', from the expression

$$\phi' = \frac{(n_1-1)(n_2-1)(\varepsilon_1^2+\varepsilon_2^2)^2}{(n_2-1)\varepsilon_1^4+(n_1-1)\varepsilon_2^4}$$

which, if $n_1 = n_2 = n$ reduces to

$$\phi' = \frac{(n-1)(\varepsilon_1^2+\varepsilon_2^2)^2}{\varepsilon_1^4+\varepsilon_2^4}.$$

In the field of quantal statistics, where quantities are always in whole numbers which give a record of events (e.g. "died" or "did not die"), and where the Binomial distribution is paramount, different procedures based on the principles already discussed are used to see how improbable an assertion of non-difference of classes may be. The most common of these is the χ-squared test, which is easily applied with resultant great economy in the time required for experiment or observation.

Both in the quantal field, as when dealing with numbers which vary continuously, one extremely useful statistical technique allows current comparison of results as they come to hand. The implication, obviously, is that as soon as data reveal the existence of difference or non-difference at any of a number of pre-selected odds, the experiment can be stopped without further to-do, leaving the operator free to turn to the next enquiry, dig his garden, or spend a little more time reading about statistics. The technique referred to is that of sequential analysis. Basically, a score-sheet is kept, and is made up to date as each result is obtained. When a quantity (i.e. a statistic) calculated from the results exceeds a pre-set value, significance at the chosen level is proved. In laboratory work, Barnard's Sequential t-test is a particularly suitable form of this method.

So far, the description and comparison of populations has been touched on, with brief mention of the comparison of classes. Turning to other matters, consider now how potentially interesting relationships may be explored.

In every school physics laboratory it is quickly learned that related data can approximate to linear interdependence if a little ingenuity is applied. Results obtained with a convex lens fall into an awkward curve if plotted directly, but by making a graph of the reciprocals ($1/v$ and $1/u$), a fairly good straight line is obtained. Using the eye alone, aided by a piece of black cotton, a line of best fit can be drawn, but this lacks formal conviction. Once more a potent instrument can be selected from the statistical tool-box, not only to fix the line ("the regression line") precisely, at the cost of a few minutes of arithmetic, but to provide assessments of the probabilities that the line really lies where the tool puts it and that the points are indeed so related. For good measure, the method also allows confidence limits to be set. The latter are two further lines, delimiting the region in which the "best" line must lie once the odds of its so doing have been chosen. One often uses 95% or 99% limits, and they mark out the region in which the "best" line stands a 95% or 99% chance of falling. All three lines pass through one point, defined by $X = \bar{x}$; $Y = \bar{y}$. Some experimental results so treated gave the graph shown in Fig. ii. It must be added with breathless haste that a mathematical relationship so found is no evidence of casual dependence, which must always be established on separate argument.

Although in large-scale industry a gain of $\frac{1}{4}\%$ in efficiency can result in annual savings amounting to thousands of pounds, it might be thought that such considerations are irrelevant in hospital and academic laboratories. Yet reflection shows that in a clinical routine laboratory the lesson of industry may provide useful precept. The wider questions of work-study have no place in this article, but one point of present interest is the examination of experimental accuracy. In order to obtain more accurate measurements than those presently made, it might be advocated that more expensive apparatus should be purchased, or that a more time-consuming method should be used. Think of the variance of the quantity being measured. Variances are additive, so for the quantity x, having a "natural" variance V_x, the variance actually observed will be $V_x + V_o$, where V_o is a component introduced by the vagaries of the experimental procedure employed. Suppose $\bar{x} = 100$ and $V_x = s_x^2 = 100$. Then confidence limits at $\pm 2s$ for $\bar{x}$ are 100 ± 20, i.e. 80–120, so that samples giving results below 80 or above 120 will be reported as abnormal. If $V_o = \frac{1}{5}V_x$, the **observed** variance will be $100 + 20$, so the standard deviation now found will be very close to 11, and the "normal" range for $\bar{x}$ will now be 78–122, which introduces

very little error. Expenditure of time and money to reduce V_x to less than 20% of the natural variance, V_x, is probably wasteful. Of course the question of bias through systematic error must be considered separately. Clearly, however, it will pay on both counts to investigate some time-honoured operations in routine analysis, whether clinical or for research.

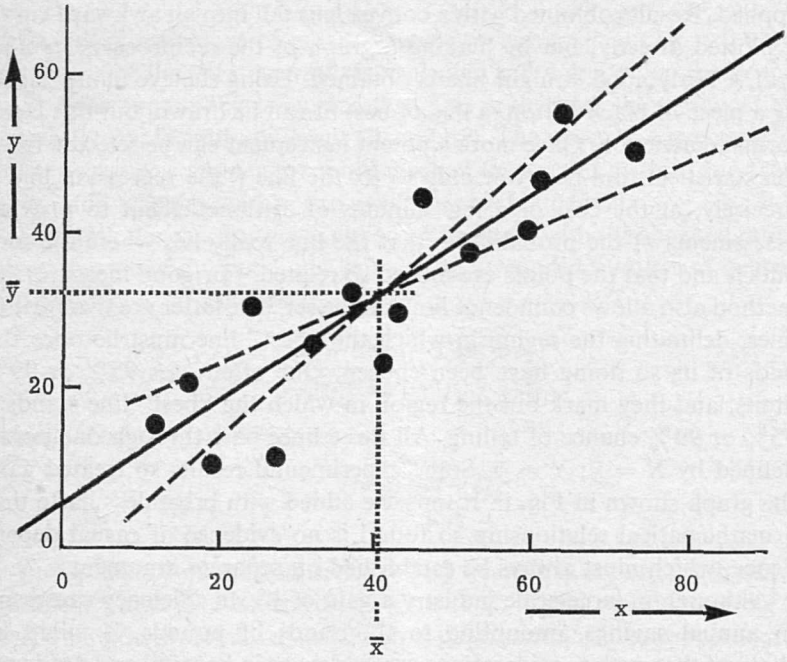


Fig. ii. A typical graph for 15 imaginary experimental results with the calculated line of best fit (regression line). The 95% confidence limits for this are shown as broken lines.

The immediate object of this contribution is to advocate on practical grounds the wider admission into laboratory work of statistical methods; no attempt at instruction is presumed. More importantly, it is suggested that a statistical viewpoint should be inculcated, especially at the planning stage in experimental work. Practice of statistical methods might kindle an interest in the subject, which can readily be nourished from the many easily readable books available. Most students entering medical schools have very little knowledge of statistics, and they tend to receive unco-ordinated short courses in the subject as they pass through. More useful to themselves and to the professions they will serve would be, it is submitted, to have instead a centralised course of instruction. They would then have a wider appreciation of what the subject has to offer and the skill to apply it, together with enhanced critical faculties.

HOMŒOPATHY

by Colin Soutar

Homœopathy has been in existence for over a century and a half. The man who first propounded its principles was Samuel Hahnemann, a Saxon who lived near Meissen at the turn of the eighteenth and nineteenth centuries. Hahnemann studied medicine, and found himself dissatisfied with the traditional principles of practice. Treatment at that time was confined to indiscriminate purging, bleeding and blistering and the administration of large doses of laudanum, mercury and various potent mixtures.

Hahnemann set himself to study in detail every conceivable clinical aspect of each patient and his disease. He noted the build and colouring, personality and temper of each patient, and correlated them with the detailed clinical course of the disease. It began to dawn on him that the symptom complexes produced in disease were commonly replicated in healthy people by the administration of various drugs. His most famous experiment was when he himself took extract of cinchona bark, and found that it produced in himself an ague exactly similar to that which occurred in Marsh Fever. Cinchona bark was known to be an excellent remedy for Marsh Fever, and is used now as a source of quinine. Hahnemann was struck by the similarity between the disease and the effects of the drug used in its treatment.

Hahnemann spent the rest of his life testing new medicines on himself and his friends and relatives, carefully noticing the symptoms they produced. He had observed how successfully hot swellings could be treated with hot poultices, how cantharides, though causing dysuria in the healthy, cured it in the sick, how rhubarb could often cure diarrhoea (Boulduc, 1710), and he formulated his therapeutic rule of treating a disease with the simillimum, the most similar drug.

He proceeded to treat his patients along these lines and found that the more similar the drug's actions on the healthy to the disease itself, the more successful was its action. He did observe that the drug often caused an initial worsening of the symptoms, but he maintained that this was usually followed by an improvement. As soon as improvement occurred, he stopped the drug. In the course of time he noticed that he was able to reduce the dose to almost infinitesimal amounts, while still maintaining the good effect. This gave rise to his second principle: always treat with the lowest effective dose.

His results compared favourably with those of his contemporaries who used traditional methods. As Trousseau said: "Homœopaths, very unintentionally and unwittingly, I admit, came opportunely to teach us to recognise the inherent forces of the living economy. Their successes, based with precision on cures which they attribute to themselves, but which belong exclusively to nature, have been useful lessons to us. They have taught us to rely a little less on ourselves, and a little more on the wonderful aptitude of the tissues and apparatus which constitute the animal machine."

Hahnemann thought that the drug competed with disease in the production of symptoms, and, being stronger, excluded it. He said: "A weaker dynamic affection is permanently extinguished in the living organism by a stronger one, if the latter is very similar to the former in its manifestations." As soon as the drug had ousted the disease, it could be withdrawn, and the symptoms would subside. Hahnemann took care to say that at no time would homœopathy take the place of surgery in conditions which were purely surgical.

Hahnemann dabbled in other mysteries. He described in the Organon of Medicine a cure to be used in desperate cases, using animal magnetism or mesmerism. He described how he cured a woman in the last stages of uterine haemorrhage by laying his hands on her head and passing them down her body to her feet. The redistribution of vital force so caused stopped the bleeding and revived the woman.

Although never accepted by the bulk of the medical profession, homœopathy is practised today and homœopathists are patronised by the royal family. Although there are so few of them, the subject has a fairly large literature and its own journal, and the society awards its own higher qualifications.

Homœopathists agree that homœopathy is no substitute for surgery and should be used in conjunction with good nursing and physiotherapy. They will admit it has other limitations. Wheeler, in Principles and Practice of Homœopathy, admits that where there are advanced pathological changes, homœopathy has little use. Gibson, in an article written for the Royal Free Hospital Medical Journal, says that, in certain diseases, such as tuberculosis and other diseases with known curable causes, orthodox medicine is better, but in diseases of unknown aetiology, such as asthma, urticaria and migraine, homœopathy is very successful.

Great emphasis is laid on the importance of obtaining every detail of the history of the disease, and of the physical and mental make-up of the patient. This takes a great deal of time, and may be an explanation of why homœopathy is practised mostly on a private basis. As the doctor listens to the patient, he recognises that the condition corresponds to the condition produced in the healthy by one of the many drugs in the Materia Medica. For instance, a bursting headache with flushing of the face occurring in a young, intelligent

patient, might well be treated with Belladonna. There are some reports that compulsive neuroses, especially compulsive hand-washing, have been successfully treated with Lueticum (a treated extract of the primary syphilitic sore). Lueticum is recommended in the treatment of syphilis, and in Tabes Dorsalis.

Homœopathists offer no evidence in the form of clinical trials and surveys. They maintain that as each patient and each disease is different from the next, it would not be possible to demonstrate statistically the efficacy of their methods. They maintain that it is only by experience that their value can be appreciated, and that no doctor who has given homœopathy a reasonable trial over, say, two years, has ever gone back to orthodox medicine.

They explain the mode of action of the small homœopathic dose by suggesting that, just as drugs in increasing doses first stimulate, then depress (Arnd's Law, for example, nicotine), the tiny dose stimulates the vital force of the body to produce a powerful response, so that the disease is more easily combated. Camphor in small doses is an aphrodisiac, but in larger doses has the opposite effect. Vaccination is often quoted as an example of a small homœopathic dose being used successfully to treat disease.

To obtain the small doses, the drugs are serially diluted, sometimes to a quite extraordinary degree. Some homœopathists claim (*Daily Telegraph,* August 19th, 1954) that as the drugs are diluted, they gain in therapeutic potency, although a mixture may contain a drug diluted so much that it cannot be estimated except by electronic means. This small but mighty dose is apparently ingested in a strange manner. A pamphlet produced by the British Homœopathic Association, intended for the medical profession, states that "the absorption of the dose probably takes place directly from the mouth, and may not be either by the blood stream or lymphatics, but in some other way associated with wave-force transmission".

Obiter Dicta

LORD BROCK: No man has a right to a pulse as slow as this when I come to examine him.

MR. ROSS: Lupus erythematosus is a diagnosis for the intellectually destitute physician as fibroma is for the surgeon.

OLD LADY, showing friend around Guy's, coming to the new card rack by Smith's:—

"And this is where the students clock in."

LETTER FROM A PATIENT IN ATHENS.

" Director,

Please I am Mr. . . . . es . . .os who was injured at his leg on November 26, 1965, date of my admission to your hospital as my leg has not come to its proper position up to day. Let me have all the X-rays that I may help the here doctors for my leg healing."

"I wonder what the chaps would think if they saw me now"

(Photograph of Prof. Butterfield being made up for a television recording, reproduced by kind permission of World Medicine.)

NURSING NEWS

The Sisters' Dinner

The Sisters' Christmas dinner is traditionally a rather splendid affair and yet it has a special informality all of its own. This year's dinner was no exception and must surely have delighted the special guests, Lord and Lady Robens. The dinner itself was truly a magnificent repast, an example of impeccable cuisine, and the speeches following were equally palatable.

Matron opened her speech by expressing a warm welcome to the various guests—the Sisters who had left Guy's during 1965—and others—but particularly to Lord and Lady Robens, adding: "May I stress quite emphatically, that your appointment as Chairman to the board of Governors has given us all more support and encouragement than any other single event for a very long time".

Matron stressed with what abundant clarity 1965 had shown, that in a vast organization, unless each member of staff was truly aware of the needs and indeed of the commitments of his neighbour, then his own contribution could only be stifled, and the community would waver.

"Where are we going in 1966?", Matron continued, and suggested three goals. Firstly, that all the Nursing Services would, of necessity, be obliged to strive to spend increasing time upon the task that they came here to do—and less and less on work which could be undertaken by other channels of personnel. Secondly, perhaps we could begin to explore the possibilities of expanding the whole field of post registration education at Guy's. "Vast new fields lie ahead, and we have immense facilities which we should surely share. I would like to think that the various experimental courses now in progress in various parts of the United Kingdom, may prove to be mere chicken feed compared to what we may achieve at Guy's". Thirdly, however, and for the immediate future, she stressed the need to consolidate the ten major changes which had been implemented during 1965.

In conclusion, Matron emphasised her profound appreciation of all that the Sisters had achieved, and finally assured the gathering that: "No Matron of Guy's has ever been more proud of the Sisters than I am of you today, and I would be so bold as to say that no Guy's Matron has ever wanted to do more for the Sisters—and through the Sisters—than I do, with you during the years which lie ahead".

Lord Robens, replying to Matron, suggested that she would have had a good career in the House (Matron blushed modestly). He went on to express doubts about the security of his own position in that as Chairman of the Governors of a hospital whose new Tower Block is to have oil-fired central heating, he was likely to be fired himself! (Matron applauded.)

The Sisters' Christmas dinner was, as ever, a very special Guy's occasion and must surely betoken well for the years to come.

CORRESPONDENCE

Reviews

SIR,—Book reviews are an important and useful feature of the *Gazette*. The reviews in your issue of 22nd January are, I feel, worthy of comment.

One may wonder on the one hand how it is possible to enthuse at such length over 79 pages of a book on silver amalgam, while 664 pages on the Operations of Surgery can be dealt with in 11 lines just above—excellent though the latter was.

However, it is the appalling review of Mr. M. Lewis, of J. H. Gaddum's new edition of Pharmacology, that prompts this letter. One can at least expect a reviewer to have read the book about which he writes—after all, he is given a free copy! To use the space for flippant remarks designed only to illustrate the dubious wit of the reviewer, is to my mind merely an insult to the original author. I trust we may expect a better standard of acceptance in future, or at least let such reviewers remain anonymous to save embarrassment to all.

Yours, etc.,

PETER BANKS.

17, Beckenham Road,
Beckenham, Kent.

Sister Perkins

SIR,—May I, through the courtesy of your columns, thank all those who have so kindly and generously contributed towards the magnificent cheque which I have received as a retirement present, together with the album of signatures.

I am truly grateful for this wonderful gift which will more than pay for the installation of central heating and many other amenities in my home, and which will make my retirement so much more enjoyable.

To thank each person individually would be a delightful, but formidable task, but as I decipher the signatures, I think nostalgically over the years gone by with great happiness and wonderful memories.

I am very proud to have been associated with Guy's for so many years, and to have been remembered by so many people. There will always be a warm welcome for any of my friends from Guy's at "Little Orchard."

Yours, etc.,

A. L. PERKINS.

Little Orchard,
7, Castle Way,
Steyning, Sussex.

Mary Steel

SIR,—I would like to express my sincere thanks to so many friends at Guy's for their warmth and generous gifts on my retirement.

Yours, etc.,

MARY STEEL,
Almoner (Retd.)

Guy's Hospital, S.E.1.

As good as the Old Days

SIR,—I was very interested to read the paragraph on the new nursing staff duty hours. I trained 1906—1910; we went on at 8 a.m. and the night staff at 9 p.m. Daily off duty was one hour and three hours on alternate days, and two half-days and one whole day a month.

Night nurses had one night off each month in the first year, then two and three. Sisters were responsible for their Wards from 8 a.m. to 10.30 p.m. If you had an emergency in the theatre, you had to stay until the one surgical night sister could relieve you (the only fixed off-duty was a fortnightly week-end); there was no night theatre staff, so your night pro. had to clean up the theatre. Salaries, £8, £12, £16.

I have been a patient recently and notice that the nurses and sisters have more off duty, but they work just as hard as we did, and I hope they enjoy it as most of us did.

Yours, etc.,
(Miss) WINIFRED M. VENNERY, S.R.N.

1, Daneswood House,
Southview Drive,
Worthing.

Ladies' Guild of the Royal Medical Benevolent Fund

SIR,—May I request space in your columns to inform your readers that a Supper Party is being held in the North Common Room of the East Wing of Old Guy's House at 8 p.m. on Wednesday, the 9th of March, 1966, in order to raise funds for the Ladies' Guild of the Royal Medical Benevolent Fund. This is being organised by the combined efforts of the King's College Hospital, Bethlem Royal and Maudsley Hospital, Guy's Hospital, Dulwich, Streatham and Norwood branches; we, as hosts, should endeavour to give it our strongest support.

Money is urgently needed by this medical charity as its income is mostly derived from members' subscriptions, from donations and from " Special Efforts " (of which this is one) organised from time to time by the Branches. Please come.

Tickets are 30s. each (inclusive of wine) and can be obtained from me, preferably by the 21st of February in order to assist with the catering arrangements.

Yours, etc.,
YVONNE CARNEGIE.

Conduit Lodge,
48, Blackheath Park, S.E.3.

NOTICES

Boxing Club

The Club Reunion Dinner will be held at the new " Miller of Mansfield," Snowsfields, on Friday, 18th March, 7.0 p.m., for 7.30 p.m.

Those wishing to attend should contact me in writing as soon as possible. Please mark envelopes " Boxing Dinner."

J. MANSIE (President).

Guy's Hospital, S.E.1.

British Postgraduate Medical Federation

The British Postgraduate Medical Federation will hold a week-end course in paediatrics for general practitioners and local authority medical officers entitled " The Assessment of Infant Development." This will take place at the Evelina Hospital on Saturday, March 5th, and Sunday morning, March 6th. Applications for a place on the course should be made to the Hospital Secretary, Evelina Children's Hospital of Guy's Hospital, Southwark Bridge Road, S.E.1, as soon as possible

R. C. WEBSTER, Hospital Secretary.

REVIEWS

MANUAL OF DERMATOLOGIC SYNDROMES.

Butterworth and Strean. 1st Edition. McGraw Hill Publishing Co. Ltd. 76 pp. *Price* 28*s*.

The authors of this manual have gathered together in 52 pages (the remaining 24 pages are devoted to the index!) the chief features of some 200 (sic.) characteristic syndromes.

On counting they describe 181 syndromes and give 84 alternative names, eponymic or descriptive, for some of these syndromes.

In dermatological one-upmanship this manual provides the novice with some useful obscurities. To call psoriasis the Willan Plombe syndrome may impress the patient and fox the chief. Certainly your superiority would be guaranteed amongst dentists by the Speronsky Richen-Siegmund Syndrome.

To omit liver damage and tremor in Wilson's syndrome, but include azure lunulae makes one doubt the value of the cardinal features of the syndromes as listed.

A six months' subscription to Lewis's Lending Library costs 30s., and the money thus spent would produce infinitely greater returns.

A. BOWYER.

A NEW LOOK AT GERIATRICS.

R. Kemp. Pitman Medical Publishing Co.

This little monograph is one of the series, " A new look at Medicine." As it says in the introduction, this look describes the study and prevention of morbid trends in ageing. It is really a plea to doctors to seek out and destroy the seeds of senile morbidity sowed in middle age. Thus he says: " In my opinion we cannot hope for much progress in geriatrics unless the geriatician extends his interest to the years before he is called in as a clinical undertaker." The corollary might be for the general physician to eye the developments of middle age with suspicious concern for the patient's twilight years.

Dr. Kemp has written a scholarly and challenging account of most aspects relating to geriatrics, and I feel that it is a book that should be read by all doctors, students and others concerned with the well-being of old people.

MARTIN JOURDAN.

TEXTBOOK OF PATHOLOGY

by Bruce D. Fallis. Published by McCraw-Hill Book Co. 1964. Pp. 739.

The uniformity of the literary style and the clarity with which Dr. Fallis writes has made this book a very useful introduction to Pathology. The style is succinct and only the major diseases are dealt with in any detail. The author admits that he is purposely dogmatic upon subjects where a full discussion would be confusing, but this deficiency is very adequately covered by a comprehensive list of references at the end of each chapter.

The first part of the book is concerned with general pathology and contains many useful definitions of pathological terms. The second part deals with systematic pathology and relates the anatomy and histology of the various lesions with the clinical picture.

The quality of the illustrations is good throughout the book; photographs of gross specimens and photomicrographs are supplemented by line drawings.

This book is a valuable guide for those entering the maze of pathology, employed either as a pathway straight through it, or, by means of the references, as a starting point for the more detailed ramifications of the subject.

R. O. WELLER.

DERMATOLOGY—CURRENT CONCEPT AND PRACTICE.

Patrick Hall-Smith and Robert J. Cairns. 1st Edition. Staples Press. 256 pp. *Price* 63*s*.

The authors have sought in this textbook to provide a work " of practical use to a student preparing for his final M.B. examination and the practitioner who requires a diagnostic and therapeutic guide in his day-to-day practice," but have gone beyond this in Chapters 12 to 15 on Cutaneous Vasculitis, Drug Eruption and Urticaria, Cutaneous Manifestation of Internal Disease, Reticuloses and Tumours of the Skin. These chapters are intended to help both M.R.C.P. candidates and dermatologists in training, and the authors have been more successful in their endeavours here, where these subjects are adequately treated.

The book is well illustrated with carefully chosen photographs of conditions as seen in the clinic, unlike the more florid and exotic illustrations often met with in standard texts; and the line diagrams illustrate clearly the characteristic patterns of certain skin diseases and are helpful in the diagnosis of these maladies. The diagrams of microscopic structure, both normal and pathological, are well executed and convey clear and precise information.

The proof reading is poor. There are errors in the text as well as some contradictory statements, e.g. epidermolysis bulluso simplex, p.32 " healing occurs without scarring"; p. 205 " leaves scars and epidermal cysts in healing."

Napkin rash, which is one of the commonest skin diseases in infancy, is not described, nor discussed in the differential diagnosis of atopic eczema in young children.

The layout of material in many chapters is wasteful of space, and for a short book there is too much repetition.

Seborrhoeic dermatitis as a disease entity and a differential diagnosis appears in many chapters. One might well question the reality of this condition and its use tends to prevent the development of a better understanding of the aetiology and pathology of a small group of cases.

The authors have covered the field of dermatology adequately within 250 pages, and the greatest value of the book lies in the chapters 12 to 15. However, 63s. seems a high price to pay for these pages, money which would be better spent on one of the cheaper textbooks.

A. BOWYER.

A NEW LOOK AT PREVENTIVE MEDICINE

by P. W. Bothwell. Pitman Medical. Pp. 105. *Price* 7s. 6d.

This short book gives a superficial outline of different aspects of medical care at the present time. The author indicates the financial esteem in which preventive services are held in relation to therapeutic services, and he makes an estimate of the proportion of medical manpower employed on research into the preventive aspects of disease.

The arguments are perhaps over-simplified, and in places one is a little overwhelmed by the wealth of the mathematical information. The theme that epidemiology rather than clinical impressions should form the basis for organising medical care and for preventing disease is a sound one, though it is possible that only those who are already converted will be convinced by the evidence submitted.

This work is unlikely to help in passing exams., but it is provocative, stimulating and easily read. Furthermore, students who are concerned with the political and social aspects of medical care will find some useful information and interesting ideas in a predigested form which is easily assimilated.

J. A. D. ANDERSON.

THE QUEEN CHARLOTTE'S TEXTBOOK OF OBSTETRICS.

Various authors. Eleventh edition. Published by Churchill. *Price* 60*s*.

This well-known textbook has been thoroughly revised and brought completely up to date. Many of the chapters have been entirely re-written. The practical approach of this book has been maintained by giving little weight to untried methods or purely theoretical matter.

The book is laid out in the traditional way of obstetric textbooks with chapters on anatomy and physiology, normal pregnancy, abnormal pregnancy, normal labour, and so on. The book has fifteen authors; eight obstetricians from Queen Charlotte's Hospital, and physician, paediatrician, pathologist, anaesthetist, anatomist, psychiatrist and radiologist from other hospitals. The editor has combined the efforts of this large team so that the reader will notice few signs of the multiplicity of authorship.

For the student this book has several excellent features. It is not too big, is reasonably priced, and well produced. The diagrams are particularly good in demonstrating the mechanisms of both normal and abnormal labour.

JOHN CRISP.

A SHORT TEXTBOOK OF HAEMATOLOGY

by R. B. Thompson. Pitman. 350 pages. *Price* 35*s*.

This book has been written with a view to providing students and those preparing for higher examinations with a short but comprehensive study of haematological disease.

So many general medical textbooks fail to supply sufficiently detailed coverage to this subject, and to obtain more information the student has had to make use of some major haematological textbook. This book by R. B. Thompson effectively fills the gap between these two extremes. The book is short, but the subject is covered very adequately. Both the clinical and pathological aspects of haematology are discussed, and the book is set out in a manner which makes the understanding of this subject both simple and enjoyable.

An adequate knowledge of haematological disorders is becoming of increasing importance, and this book very effectively succeeds in supplying this knowledge. It is an extremely easy book to absorb and doesn't take very long to read, but at the same time the subject is covered in an interesting and comprehensive manner.

The student and post graduate will find that the information obtained from this interesting book will greatly repay the short time required to read it.

R. SPURRELL.

A SHORT TEXTBOOK OF VENEREOLOGY.

The Sexually Transmitted Diseases. R. D. Catterall. English Universities Press Ltd. 1965. *Price* 15*s*.

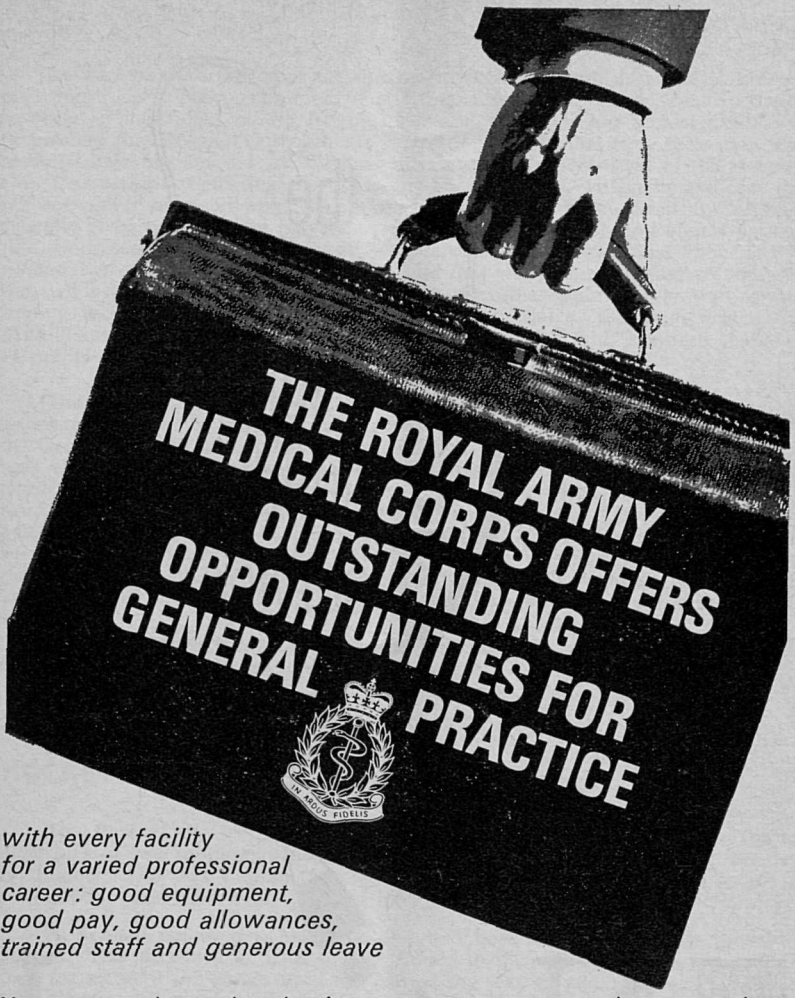
This book is clearly presented and easy to read. The author subscribes to the present-day view that this subject concerns those disorders, in both sexes, which are related to, and follow upon, sexual intercourse. The book covers the whole subject; although the habit of prefacing remarks on syphilis with a long irrelevant chapter on the treponematoses, which are mostly non-venereal, should have been resisted.

There are some rather grandiloquent introductory passages, and there is a very useful chapter on local, mainly genital and non-venereal conditions, not covered in the usual textbooks.

This volume omits photographic illustrations for the sake of keeping down the price, but presents us with abominable line drawings in their stead.

An inexpensive book and one which has a place beside the two other modern standard textbooks on the subject.

A. S. GRIMBLE.



with every facility for a varied professional career: good equipment, good pay, good allowances, trained staff and generous leave

You may not know that the Army nowadays provides *more* women and children than soldiers as patients for its General Practitioners But not only are the opportunities wide and varied: the conditions of service are such that they permit a professional man to work in a professional way.

The R.A.M.C. provides modern surgeries with first-class equipment; *trained staff to help; a car and driver.* All general practitioners are given postgraduate training and have access to *military hospitals.*

Pay for a married Captain (the rank on entry) is over £2,000 with increases every two years and on promotion. Children's Educational Allowances are paid. A five year Short Service Commission earns a tax-free gratuity of £3,000, and there is excellent retired pay with Terminal Grant for those who go on to a career in the Corps.

Six weeks' annual leave is normally granted, and reliefs are provided. Married general practitioners get a *furnished house at low rental.*

For further information please write or pay a visit to Col. A. D. Young, DSO, MB, Dept. 384, *Ministry of Defence* (AMD 2), Lansdowne House, Berkeley Square, London, W1

National Provincial

The Guy's Hospital Office, which is opened for your especial use, is under the management of Mr. A. C. Edwards, Southwark Branch, 10-14, Southwark Street, London, S.E.1, and enquiries will be welcomed.

SPORT

As may be observed from the diary below, the Hospital is about to embark once more on a full programme of sporting activity. Over the past fortnight, however, it has fallen to the Rugby Club and Hockey Club almost exclusively to provide the Hospital with athletic interest. In this, however, they have succeeded admirably, for the 1st XV have advanced to the semi-final of the Hospital Cup Competition, defeating the holders, "The London", with a magnificent display of power rugby in which maximum effort was demanded from and enthusiastically given by all fifteen players. It was the determination and vigour perhaps that impressed the most, for one was left pondering over the even greater potential of a confident and competent side that would be prepared to run with the ball as well, thus creating scoring chances rather than merely waiting and hoping they would turn up. Following the cup match, the team visited Old Millhillians in a somewhat subdued spirit and returned with honours shared at 11 points each.

The "A" XV meanwhile seized the opportunity offered by relatively weak opposition to further improve the season's points tally. In their encounter with St. George's in the first round of the Junior Cup, 69 points enabled three members to score hat tricks and gained them traditional priority in the bar afterwards to supply jugs. The following Wednesday, Woolwich Polytechnic's aspirations to play the 1st XV were cruelly shattered when the "A" scored a second half-century, there being on this occasion a curious marked deterioration in play as any individual scored his second try. The side was finally brought to earth on Saturday by Wimbledon 1st XV, when a similarly subdued spirit to that which plagued the first team, led to a 5—3 defeat—the first for fourteen weeks.

A short summary of the Hockey Club's activities and prospects from the Club Captain, Colin Brooks, is recorded below.

HOCKEY

The start of the second half of the hockey season brought the unexpected departure of two prominent members of the 1st team, D. Loader and P. Bennett. D. Loader, who was Captain two years ago, has been a tremendous source of strength for nearly five years, and we have lost, in him a very experienced player.

P. Bennett achieved a half blue and had been one of our most promising players. His place will be hard to fill. Added to this, D. Carruthers is unable to play for most of the games until the end of the season, and so it was a different team that started out this January. Fortunately in M. Velacot we have a very sound full back, who in the few games for the 1st team has established himself as a very reliable defender.

P. Brown and D. Steer have also settled down in the inside forward positions, and in fact we now hope to knock out Barts. in the cup, which is our immediate objective.

The results so far this month are, that we lost to Wallington 1—0 on a very muddy pitch, and drew 2—2 with Old Creighlonians. Both results might well have been in our favour with a little more determination by all our players.

In our last match before the cup replay, we showed some good movements, and the fact we drew 2—2 only draws attention to the number of missed opportunities we had.

With numerous supporters on Wednesday, 2nd February, we shall, I think, be able to pass through into the next round.

DIARY

Feb. 5.—Rugby v. Coventry. At home.
Hockey v. Westminster Bank. At home.
Soccer v. Icarus. Away.

„ 8.—Rugby. Semi-final Hospital's Cup v. Charing Cross. At Richmond.
Squash v. Bart's (Cumberland Cup). At home.

„ 9.—Soccer v. St. George's (League). At home.

„ 12.—Rugby v. Oxford. At home.
Hockey v. Walton. Away.
Soccer. 2nd Round Hospitals Cup v. Charing Cross. Away.
Cross-Country. United Hospitals' Championships. At Chingford.
Squash. Cambridge Tour.

„ 16.—Cross-Country. South West Essex Technical College Invitation.
At Walthamstow.

REPORTS & RESULTS

RUGBY FOOTBALL

2nd Round, Hospitals' Cup

GUY'S v. THE LONDON HOSPITAL

At St. Bart's Ground.
Tuesday, 25th January, 1966

Result: won 9—0

It was a cold and rainy afternoon at Chislehurst for the eagerly-awaited second round clash between Guy's and The London Hospital, the holders of the Trophy. As a result of this win, Guy's must have established themselves as favourites to win the Cup, which we held last in 1961.

There is no doubt that Guy's fully deserved their win, and the foundations for the success were achieved by the strength of the pack, who outplayed their opponents in all aspects of forward play. They were faster as a unit on the loose ball and much better able to exploit mistakes by their opponents which was exemplified by the manner in which they obtained the second score. We had a wealth of possession from the line-out and in the set scrums we had one heel against the head. It is difficult to single out individuals in such a fine pack, but credit must go to Davies, the captain, for his example and general industry; Peace, Cockburn and Kingdon for their clean catching in the line-out; and Sharp and Thorburn for their general play around the field. Thorburn in particular was outstanding both in defence and attack and seemed always in the right place at the right time.

Behind the scrum, Elliott, in addition to kicking two penalty goals, was a tower of strength at full-back. His fielding and catching in the wet conditions was inpeccable, and he would seem to have a bright future. If there should be criticism following this splendid victory one should say that Rowlands, despite the usual steadiness in his general play, failed to bring our fast and elusive wings into the game, and his kicking was often misdirected. His partner, Swift, was particularly sound in his defensive kicking from the base of the scrum, and often made valuable ground, but his service to Rowlands was somewhat slow and in particular he should not delay his pass by running a few yards unless he has decided to make the break. Ross showed again how dangerous he can be when given a chance by brushing past five opponents close to the touchline in the first half but was finally overpowered by weight of numbers. Morgan did all that was asked of him. Edgar and particularly Lindsey were sound in defence and the former deserves praise for his well-taken dropped goal.

The exchanges were even in the first quarter, but it was evident that Guy's were gradually getting the upper hand, particularly in the line-outs and loose play. Elliott had a chance after five minutes to kick a penalty goal from 35 yards but was just short of the distance. Then Edgar nearly broke through following a judicious stab kick by Lindsey, but the London cover defence held firm. A very good movement in which all the threequarters handled from their own 25 had their opponents at full stretch, but again the London stemmed the tide. Both sides tended to hug the touchline for most of the rest of the half but finally, after a short period of attacking by Guy's, Elliott put his side ahead with a well-taken penalty goal from 30 yards.

The second half began in exciting fashion as the London tried desperately to score, but the Guy's defence was sound. After 20 minutes, the London carried through the best threequarter movement of the game which began in their own 25, first going left and then right over a distance of 50 yards. The movement finally broke down when Lindsey tackled his opposite number, and it was then that the Guy's forwards took command, and in a well executed forward rush led by Thorburn, they took play back to the other end where London were penalised for lying on the ball. Elliott made no mistake with the kick from 25 yards. Following this reverse, the London tried everything to pull the game out of the fire but it was evident that the Guy's pack were in control having established a clear cut line-out supremacy and an ability to make good use of any mistakes by their opponents. After 35 minutes, Edgar dropped a goal as he was falling, from 25 yards, which seemed to settle the issue beyond all doubt. Finally, Cockburn seemed to have scored when he burst through

on the blind side from a set scrum near the London line but the referee did not allow a try.

Guy's now meet Charing Cross Hospital in the semi-final of the competition on February 8th.

Guy's: D. Elliott; J. Ross, M. Lindsey, A. Edgar, I. Morgan; B. Rowlands, P. Swift; J. Davies (Capt.), G. Hey, R. Stansfield, A. Kingdon, P. Peace, H. Sharp, M. Cockburn, C. Thorburn.

D. CARROLL

GUY'S v. OLD MILLHILLIAN'S

Away Saturday, 29th January, 1966

Result: drew 11—11

Although the pitch looked a little on the heavy side, conditions were almost ideal for an open game at Headstone Lane. Open rugby is certainly a rarity as far as Guy's are concerned, but in the opening minutes it looked as if Davies, after his brilliant tactical victory in the pack against the London Hospital, had told the half-backs to move the ball out as much as possible.

After ten minutes, I. Morgan just failed to hold on to a superb diagonal kick by B. Rowlands, which would almost certainly have led to a try for the speedy winger.

Unfortunately, rather scrappy play ensued with both sides dropping too many passes to look really dangerous.

At the end of the first quarter, the O.M's. hooker surprisingly took two against the head to bring the home side within striking distance. However, a dropped pass in the centre, followed by intelligent hacking on by the Guy's pack, resulted in a loose maul on the half-way line. The ball was heeled quickly to Rowlands who put in another superb diagonal kick to the left wing, which Morgan and Edgar kicked on to the O.M's. line, where Morgan scooped up the ball and, in customary manner, dived over near the posts. Elliott converted.

The Guy's pack now began to get the ball consistently from the loose, and fly-half Rowlands was confounding all his critics with a brilliant display, both in attack and defence. A loose maul on the O.M. 25 resulted in a penalty for Guy's for offside, and Elliott competently converted to make the score 8—0 in Guy's favour.

Just before half-time, a handling incident in a loose scrum by a Guy's forward gave the O.M. fly-half a simple chance to reduce the arrears, which he did without trouble. Guy's must learn not to give away stupid penalties in their own 25, and with their superiority in nearly all aspects of the game they should have been more than a meagre five points up at half-time.

The second half was a complete reverse of the first, with O.M's. completely dominating the game up to the last ten minutes. After a good move by the O.M.'s. backs, the ball was heeled by their forwards on the Guy's 25, and the scrum-half went blind to sprint over in the corner, somehow beating three men. The conversion was missed, but only five minutes later the O.M. scrum-half made another break from a loose maul and an inside pass to his left-wing saw the latter dive over half-way out. The fly-half converted with a fine kick.

O.M's. were now well and truly on top, and some of Guy's attempts at tackling were pitiful. However, good tackles by Elliott, Edgar, Lindsey and Stansfield did stop possible tries.

In the last ten minutes Guy's stepped out of their complacency and a beautifully-timed pass by Lindsey nearly saw Edgar over. A superb break by Kingdon should have resulted in a try, but Davies passed the ball to the tall, coloured O.M. winger instead of Bundred. The Guy's backs now looked dangerous again, and obstruction on Bundred gave Elliott a chance to level the scores, which he did.

Guy's looked rather tired at times during the game, but this was not surprising as some of the pack had played three games in seven days. Thoughts must now be almost solely on the Cup, and the team must know that if ever a Guy's team was capable of winning the Cup, then this must be the year.

J. R. M. ROSS

BOAT CLUB

University of London Winter Eights Regatta

This event took place on Saturday, 4th December. For the first time for many years Guy's entered three eights.

There was a certain amount of indecision beforehand as to whether we should enter the first VIII in the Junior Division, or not. It was decided, in view of the past performances by one or two of the crew, that we were obliged to enter the Senior Division, where we met King's in the morning, in the first round. Guy's won convincingly, and enjoyed this "warming-up" outing. The main trial was to come at 2.45 p.m., when we rowed against two crews, who we usually regard with great respect. Guy's were drawn on the least favourable station for this race (the Surrey station) but made a very good start. For most of the race there was very little to choose between Queen Mary College, University College and ourselves. Guy's and Q.M.C. slowly left U.C.L. near Quintin Boathouse; Guy's having had the disadvantage of the bend in the river, lost about a length when Q.M.C. spurted. This distance was too much to regain by the finish, so, despite a fine effort, we lost to the eventual winners by ¾-length.

The 2nd and 3rd VIII's were entered in the clinker division. The 3rd VIII, which rowed first, consisted of oarsmen who had not rowed before this term and thus had all been trained to row at Guy's. They were doing extremely well, having made a good start, but lost a little water due to inexperience. They were superbly fit and were re-gaining fast on the other crews (Q.M.C. and U.C.L.) when a sculling boat, on the course illegally, rowed straight into them. They were granted a re-row but this not only involved using a heavy and strange, borrowed boat, but also meeting our own 2nd VIII in the same heat, so that at least one crew was bound to lose. This heat, in which Bart's 1st VIII was also rowing, was lost by two lengths, but with honour.

Having beaten Bart's in the above heat, the 2nd VIII went on to meet and beat Q.M.C., with no trouble at all, in their semi-final. In the final they met U.C.L. Just before the race they suffered a most unusual collision with a Bart's boat. The two crews struck head on and became inextricably entwined, and had to row back to the boathouse as a "XVI". There were fears that another boat would not be available in time, but a very friendly loan by Battersea College solved this problem. The race was rowed in near darkness, making events during the race a little uncertain. However, there was no doubt about the result, which was a resounding and easy victory for Guy's.

The most satisfying feature about the win in this regatta is that it is a prize which Guy's

'Physeptone' brand Linctus

suppresses severe cough

contains Methadone Hydrochloride B.P. 2 mg. in each dose (one fluid drachm)
Subject to the D.D.A.

(For further information see your Wellcome Medical Diary)

Burroughs Wellcome & Co. (The Wellcome Foundation Ltd.) **London**

has long narrowly missed, so that honour is at last satisfied. Also, the majority of members of the Club have now rowed in events won, gaining invaluable experience, not to mention individual trophies at home!

1st VIII

Bow R. Manderville.
2 J. Pook
3 G. Stygall.
4 P. Gooder.
5 P. Burton.
6 P. Telling.
7 R. Morgan.
Stroke R. Forrest.
Cox C. Woodhouse.

2nd (winning) VIII

Bow R. Salt.
2 P. Moulder.
3 J. Swain.
4 R. Archer.
5 M. Mace.
6 A. Hodgkison
7 N. Pinckney
Stroke J. Osborne.
Cox T. Kirk.

3rd VIII

Bow J. Bates
2 P. Sharpe
3 J. Rosenberg.
4 N. Longhurst.
5 T. Haywood.
6 A. Bell.
7 J. Pitt-Payne.
Stroke P. Hunt.
Cox J. Williams.

JONATHAN WILLIAMS,
Hon. Secretary.

CROSS-COUNTRY

Guy's started this year's cross-country season looking to be certain winners of the Small Colleges' Cup in the University Championships. On the day, however, we had a very depleted team and were beaten by our nearest rivals—St. Bartholomew's Hospital. The course was over 5½ miles of Parliament Hill Fields. 108 runners finished, and Guy's came 7th out of 12 teams.

29, P. Witting; 34, B. Smith; 43, J. Wheeler; 54, E. Bowen-Jones; 60, B. Avery; 68, R. Wilson.

Over Christmas, the Club lost P. K. Witting probably the best and most consistent runner the Hospital has had for years. His determined running at the front of the field has been instrumental in establishing the team high in the University rankings.

The first fixture of 1966 was the U.H. Club Handicap, run over six miles of the new U.H. course at Chingford, on 8th January. Only 12 runners entered and R. Wilson finished 6th.

On 19th January, a day so cold that most other sports were cancelled, a Guy's team ran over 5½ miles of snow and ice at Parliament Hill Fields in a Division II match of the London Colleges League. 91 finished the course.

12, R. Wilson; 25, B. Smith; 26, E. Bowen-Jones; 82, M. Henry

Three days later, the team ran in the very exhausting Q.M.C. invitation 7½ miles Championships at Brentwood, Essex. This race attracted over 160 starters from some of the best university teams in the country. Although much of the course was over very heavy plough, D. M. Turner, of Cambridge, set a new record. The Guy's team, particularly B. Smith and G. Waterhouse, ran a very spirited race.

68, B. Smith; 94, G. Waterhouse; 102, R. Wilson; 124, E. Bowen-Jones; 132, D. Halestrap; 142, B. Avery.

The most recent race, on 29th January, was a U.H. match v. the Metropolitan Police and Aylesford Paper Mills. Six Guy's men represented the U.H. team, which won quite easily. The course was over 6¼ miles at Hayes. 40 finished.

11, B. Smith; 17, R. Wilson; 22, E. Bowen-Jones; 25, D. Halestrap; 28, B. Avery; 38, R. Ibbotson.

If the team runs just a bit more aggressively, we still have a chance of beating St. Bartholomew's Hospital and winning the U.H. Championship at Chingford on February 12th.

R. M. WILSON

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Physical Medicine** for the period 1st April to 30th September, 1966. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **14th February, 1966.**

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Applications, giving two references, to Physician Superintendent, within 10 days.

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UNIVERSITY OF LONDON

1st Examination for Medical Degrees
December, 1965

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Anne M. Gaskell (Surgery, Orthodontics)
J. V. Holland (Dental Surgery)
T. J. Storrs (Pathology and Bacteriology)
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J. M. A. Wilton (Dental Surgery)

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J. Cutler — T. W. Negus
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R. G. Daniel — Mary L. Reidy
R. A. Darracott — R. Robinson
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2nd B.D.S.

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Dental Prosthetics

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K. A. Eaton — A. A. D. Reed

PERSONAL

Assistant or associate dental Surgeon required immediately. Four surgeries, laboratory, large flat, garden and garage available if required. Principal at Guy's Friday afternoons in February. McGuckin, 6, Brookvale Road, Southampton. Telephone 56449.

CHANGES OF ADDRESS

G. A. Lawrence, F.R.C.S., and Gillian Lawrence, M.B., B.S., to 53, Victoria Street, Amherst, Nova Scotia, Canada.

D. B. Waters, Esq., 53, Broad Street, Shropshire.

BIRTHS

EVANS.—On January 4th, to Kenneth and Ann Evans, a daughter, Jane Caroline, sister for Sarah and Daniel.

FANNING.—On January 17th, at Old Windsor Hospital, Windsor, to Joy (née Carter) and Dr. Paddy Fanning, a son, Patrick John, a brother for Andrew and Anne-Marie.

RICHARDS.—On December 20th, at University College Hospital, to Sara and Andy Richards, a daughter, Belinda, a sister for Melissa and Emma.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

MARRIAGE

WATERS—QUANT.—On January 1st, 1966, at St Mary's Church, Hayes, Middlesex, Denis Ballantyne Waters, L.D.S., R.C.S., to Valerie Quant, S.R.N.

DEATH

BEATON, Charles E. F., M.R.C.S., L.R.C.P., on 18th December, 1965, suddenly at 18 Leinster Road, Muswell Hill, N.10.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2023

PASSIM

The Not So Super Structure

With the Residents' play coming round again like an annual harbinger of Spring, it is perhaps surprising the humdrum and obsequious business of keeping up the established attitude of juniority has still not received more serious questioning. For in the medical profession probably more than in any other walk of life, the most markedly anachronistic social charades are daily performed in a manner that is little short of a parody of schoolboy law. That Guy's is no exception in exemplifying this over-stratified social structure is evident to most of us (though as a generalisation there are many notable cases where this obviously does not apply).

Yet the fact remains that in many instances, up and down the professional ladder from first year student to consultant, it is still a presumption for the junior to speak to the senior and a condescension for the latter to reply. The assumption of rigid ranking though patently necessary in the operating theatre and under similar conditions, is continued in social and academic surroundings often to a slavish degree. And it is fatuous but true that the extent of this seniority may sometimes be measurable only in months.

There are very few advantages to Guy's or to Medicine in maintaining such a marked degree of differentiation. Indeed it preserves a state of affairs in which social diplomacy tempts integrity and jealous privilege-mongering mars free intellectual exchange. The net effect is that few people are really encouraged to become involved in the hospital; there are too many self-seeking and disgruntled visitors and too few responsible owners and although the motto may be to give rather than receive, the practice as regards Guy's itself, is too often the reverse.

The reasons for this situation are many and varied. The time-consuming nature of Medicine itself makes adequate contact with all but one's most immediate colleagues infrequent and for some, perhaps, also uninteresting. On the clinical side, however, where the favours of the powers that be are the not-so-mythical requirements for success, the nervous protection of ambitions must certainly play a part in maintaining the status quo.

Whatever the causes, and despite its source of amusement, this out-of-date social behaviour pattern is something to be regretted. Too many lights are hidden under bushels and the full potential of Guy's as part of a university is inhibited by the present atmosphere. Therefore, even though revolution is both unlikely and undesirable, some hastening of the course of change would be to the benefit of all.

Starched Cuffs

It soon becomes apparent to students when they come to work on the wards that each ward has its own atmosphere and personality. As the staffing on a ward is done on a rotating basis, this appears to arise from the two more permanent features of the ward, namely the type of illness which it deals with and the ward sister herself. In general it is the sister's attitude that matters most.

There are several aspects of award organisation affected by the sister that students find inconvenient, inconsiderate and sometimes frankly distasteful. Unhappily these differences arise out of a lack of understanding by the students and the sister of each other's programme and duties. For example, notices pinned up by the sister on her ward informing students of the times when they will not be allowed on the wards too often show no appreciation of the students' time-table of lectures and demonstrations which he is also obliged to attend. The imposition of these restrictions implies that the sisters have at sometime been inconvenienced by inconsiderate students. But this is no ground for developing an unhealthy attitude to students which can only generate an inappropriate atmosphere in which the ward staff (of which the students are part) is expected to work.

Students should know the ward times for washing, bed-making, meals and visiting and should avoid doing their investigation at these times or others inconvenient for their patients or the nurses. The work of the sisters is extremely pressing and students should be aware of this at all times, then their consideration and courtesy to the sisters will not lapse. In general, this is already the established practice, and therefore curt notices from sisters are entirely unnecessary. At the best they result from a trivial misunderstanding and at the worst they reflect a sister's unnecessary departure into authoritarianism.

Here there are grounds for useful communication between the nurses and the medical teaching staff. This would facilitate recognition of people's duties and responsibilities, bring about an atmosphere more suited to co-operation and civility, and doubtless, an increased efficiency.

News Flash—"Revolution! A matron makes her hospital like home."—*Daily Express* article on Guy's.

Mr. R. J. Cann has been appointed Acting Superintendent during Mr. Blaikley's absence on sick leave.

Mr. P. Clarkson will be lecturing on "Modern Mammaplasty" in Universities in Southern France in March, on behalf of the British Council.

It is with profound regret that we record the death of Dr. J. A. Nissim, of the Department of Pharmacology, on Sunday, the 6th of this month. A tribute to Dr. Nissim will appear in the next issue of the *Gazette*.

The Guys' Debating Society, which has remained silent since the last General Election, suddenly broke into voice again on Wednesday, the 2nd of February. A full report of the debate with a team from British Railways is contained in this issue. We wish the rejuvenated Society every success.

GUY'S DIARY

FEBRUARY

Exhibition :			Thyroid Surgery.
22nd	Tu.	1.00	Clinical Lecture. Mr. CLARKSON. "Modern Mammaplasty".
22nd	Tu.	1.00	Clinical Lecture to Dental Students. Professor W. J. TULLEY. "Dental Treatment for Children—the Present and the Future." Dental Theatre.
24th	Th.	1.00	Clinical Lecture. Mr. WASS. "Undescended Testicles".
24th	Th.	5.00	Psychological Society. "Measurement of Personality". Professor H. J. EYSENCK.
25th	Fr.	1.00	Clinical Lecture. Dr. HILLS.
25th	Fr.	1.00	Clinical Lecture to Dental Students. Mr. K. E. PRINGLE. "Orthodontic Treatment".
25th	Fr.	2.15	Combined Round. Professor BUTTERFIELD and Dr. DONALD HUNTER.
26th	Sa.	10.00	Clinico-Pathological Meeting in the Clinical Theatre.

MARCH

1st	Tu.	1.00	Clinical Lecture. Professor BUTTERFIELD. "Osteoporosis".
3rd	Th.	1.00	Clinical Lecture. Mr. LAWRIE. "Divertculitis".
4th	Fr.	1.00	Clinical Lecture. Professor BUTTERFIELD.
4th	Fr.	2.15	Combined Round. Dr. TROUNCE, Dr. DEUCHAR and the Cardiac Department.
7th	M.	1.00	Clinical Lecture. Mr. BLACKBURN. "On Examiners and Examinations".
8th	Tu.	1.00	Clinical Lecture. Mr. BEARD.
11th	Fr.	1.00	Clinical Lecture. Mr. BEARD.
11th	Fr.	2.15	Combined Round. Dr. TROUNCE and Dr. BISHOP.

Obiter Dicta

Overheard in the Nurses Home following the Staff Nurses' Dinner:—

Hostess (to popular Casanova): "Oh!—and who gave you that buttonhole!"

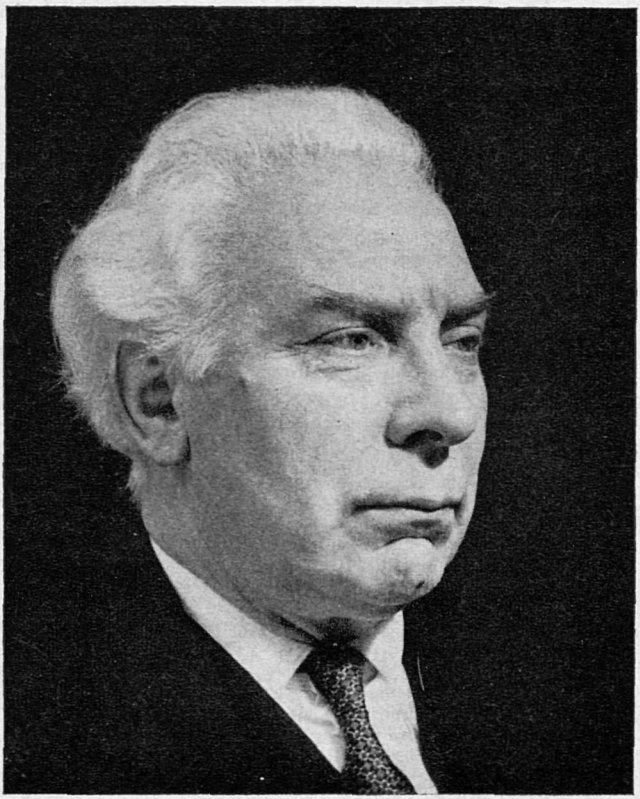
Casanova: "Ah! Ha—! One of the Staff Nurses."

Guest of Honour: "Now look here B.,—none of that,—we can't have you upsetting all the duty rotas!"

Casanova: "Oh! Don't worry, Sir. I can now enjoy the girls in shifts—!"

Mr. R. J. Cann

— an appreciation



Many many generations of Guy's men will be saddened to hear that "Bobby" Cann, touched, like all of us, by the remorseless finger of time, has retired from the surgical staff. Not that time has taken its toll of his mental and physical qualities. His mane of hair is, it is true, white, but white it has been for many years, and it is as thick as ever. His eyes are as clear and piercing as ever they were thirty, nay forty years ago, his memory as retentive, his grasp of the essentials as masterly as ever.

He has had a long and successful career. Almost since the time when he was house-surgeon to Mr. Steward, it was clear that these gifts, for which the ordinary mortal so often pines in vain, had been lavished upon him with a generous hand. He first made his mark

as a student, then as houseman, when he was awarded the University Gold Medal in passing the M.S. examination of the University of London, and finally as Clinical Assistant (as registrars were then known in the Ear and Throat Department). In those far-off days before the war, a man over thirty-five could not be appointed to the Consultant Staff, and the Governors had to move fast to secure his appointment before the fateful birthday. A post had to be created for him, that of Assistant Surgeon in the Ear and Throat Department, where no such post had existed before. And now, thirty years later, another birthday forces his retirement from active clinical work in that Department. In those thirty years how much has he done, how much contributed!

No one, not his students, not his house-men or ward sisters, certainly not his patients, needs to be told of his skill in diagnosis, his patience and firmness, his dexterity in operating. No one will forget his extraordinary acuity, which not only enabled him to "see" a tympanic membrane, to perceive the trivial changes of colour and texture, but also to interpret those changes in terms of disease. At a memorable meeting of the Section of Otology of the Royal Society of Medicine, the advertised speakers had read their papers on the subject of "Serous Otitis", a hitherto little known disorder, when he stood up in the body of the hall and spoke. His speech was unrehearsed, he referred to no notes or memoranda; those of us who had worked with him in the clinic had heard it before from him, and often thought that these facts, so often expounded, were more or less widely known. To our surprise, his description of the colour of the membrane, of the technique of puncture of the membrane and many other details, came as a revelation to the large audience. Only then did we realise that these rather familiar details were his original observations. To another man, they would have furnished the matter for several learned papers, to him they were just some things he had noticed. The incident illustrates his acuity of observation and his modesty.

In his later years as a clinician, several honours were thrust upon him. He was made, honoris causa, a Fellow of the Royal College of Surgeons of England and a member of the Board of Examiners of that College. He was elected President of the Section of Laryngology of the Royal Society of Medicine.

The esteem of his colleagues on the staff caused them to choose him as Chairman of the Medical Committee and Chairman of the School Council. The Governors of both hospital and school elected him to their Boards. For the last few years, in addition to coping with his clinical duties, he has unwearyingly expended his energies in the service of the Boards, guiding by his counsel those innumerable sub-committees, which unseen by the public eye, control the working of this enormous organisation and plan its development. New Guy's House stands as one tangible memorial to the labour of these committees and this man.

Now, at the age of sixty-five, he leaves the clinic and operating theatres, and patients and staff will mark his absence with regret.

Retirement to a house in the country, gardening, and the arrangement and indexing of the large library of rare books which he has acquired over the years, are really not enough, he finds, to occupy the energy of a man sixty-five years young. So he has been appointed Acting Superintendent of the Hospital. To our relief, we are able with warmest affection to cry, "Ave" not "Vale" to this man, who in himself and in all his past activities, has epitomised for all who knew him the veritable spirit of Guy's.

Mr. Charles Engel

— an appreciation

Mr. Charles Engel is leaving Guy's at the end of February to become Director of the Department of Audio-Visual Aids in the University of Melbourne. He was invited to fill this post, which carries the rank of Reader by the University, and his new duties research and teaching, cover all the faculties.

Everybody will congratulate him on his appointment, so much wider in scope than his present, but all will feel sorry at his going. Guy's is losing one of her brightest sons.

A brief, and very condensed, story of his academic career may bring home to us the extent of our loss. After schooling at St. Edward's School, Oxford, and St. Paul's School, London, he at one time considered entering the medical profession. Circumstances dictated that he had to take a technical training at Birkbeck College. After six years in the infantry during the War, he came to the Guy's Illustration Department, where he worked for a time under Miss Sylvia Tredgold. Very shortly, the department underwent binary fission, and he became the senior photographer to the Medical School, while Miss Tredgold became chief artist.

He bent all his efforts to improving the standard of medical photography at the hospital, and at the same time his amazing vigour enabled him to take part in many extra-mural activities, all connected with audio-visual aids in medical education. He became member of four associations, foreign corresponding member of two, and fellow of three, of which the Royal Photographic Society was one.

He founded and edited "Medical and Biological Illustration", a quarterly, published by the B.M.A.; and has written one technical book, "Photography for the Scientist", and 30 or more papers in learned journals. He was at one time, chairman of the Medical Group of the Royal Photographic Society, and at another, organizing secretary of the Teaching Services Section of the same society. Space does not permit a recital of his activity in the London School of Medical Photography or as an examiner in the Final Medical Examination in the Institute of Incorporated Photographers.

He was, with Professor Foxon, a member of the Department of Scientific and Industrial Research Working Party on the "Film in Scientific Research" and his evidence was invited by the U.G.C., and Department for Education and Science on an enquiry into audio-visual aids in higher scientific education. He has lectured to many academic conferences in this country and abroad; and with Professor Warwick, pioneered a colour transmission from a B.B.C. experimental unit to illustrate situations in which television might be of value in medical education. He also planned the remotely controlled video-tape installation in the Child Psychiatry Department.

Four of his teaching films have won British and foreign premier awards; and he did much to popularize the lantern slide type of film on loops in self-contained cassettes. In still photography he made an important contribution by designing automatic theatre cameras, copying cameras, and skin close-up cameras, amongst others.

His last development was a method of duplicating exhibitions on photographic linen, which will prove invaluable where exhibitions have to be transported any distance. In the last months he has been increasingly interested in self-instruction teaching systems, and we look forward to further developments in this field from his fertile brain and boundless energy.

This recital of past achievements, and many are omitted, shows what sort of man we have been entertaining these last years. We can be proud to send him forth; he is a tribute to the soil which nourished him, perhaps sometimes on a rather thin diet in the way of accommodation and encouragement. He will leave many friends behind him in this hospital; one and all we wish him, and Mrs. Engel, a safe journey, and happiness and prosperity in the wider fields to which he has been called.

ELECTRONICS IN MODERN CARDIOLOGY

by Dr. John Winter and Dr. Hywel Davies

Introduction

It is probably no exaggeration to state that nowadays the processes concerned with diagnosis and treatment of heart disease depend to a large extent upon electronic equipment. In this article we shall endeavour to justify this statement.

Diagnosis

Electrocardiography. The electrocardiogram is, of course, one of the most widely used aids to diagnosis and represents one of the earliest applications of electrical techniques to medicine. Since the early days, when Einthoven and his successors used the string galvanometer as the essential moving part of the recording system, there have been many technical advances in the instruments used, as a result of which they are capable of greater accuracy and are much smaller and lighter than their predecessors. The electrical manifestations of cardiac activity, as detected on the surface of the body, are amplified and transmitted to the moving part of the electrocardiograph which records the tracing directly on special sensitised moving paper. Methods requiring photographic development have now been largely superseded for simple electrocardiography though they still have a place in some of the techniques mentioned below. In **vector-cardiography,** the normal scalar leads are compounded by means of a cathrode ray oscilloscope to yield a vector loop which may be photographed. This technique has little clinical application but has played a major role in electrocardiographic research and is of some value in teaching electrocardiography.

External transducers (applied to the intact skin). Although the electrocardiogram is the most widely used electronic aid to diagnosis in cardiology there are many occasions when other types of information are required; these may be obtained by the use of other transducers (devices which change one form of energy into another). Thus using microphones placed on the chest wall vibrations of audible frequency, i.e., those which are heard with the stethoscope are transformed into electrical signals which can be amplified and recorded as phonocardiograms; high and low frequency cut-off filters are usually included in the system to make the response of the machine more like that of a human ear. Other devices, such as the apex cardiogram and the ballisto-cardiogram record lower frequency manifestations of the heart's mechanical activity. Records of respiratory phase and arterial or venous pulses can be similarly obtained. The greatest value is derived from this type of study when several such tracings are produced simultaneously using multi-channel recorders.

Cardiac catheterisation. This involves the introduction into the cardiac chambers and their associated vessels of catheters through which blood samples can be withdrawn and through which the relevant pressures may be recorded, by means of other transducers. The exploring end of the catheter is inside the cardiovascular system; its lumen is filled with fluid; connected to its other end is an otherwise closed fluid filled system, part of which is formed by a thin diaphragm capable of progressive (linear) deformation with changes in the pressure of fluid in the system. This deformation in turn causes changes in the resistance, inductance or capacitance respectively of various suitably linked electronic circuits. These changes in turn are represented by changes in the electrical signal fed to a recording galvanometer. By calibrating the galvanometer in terms of known pressures from a column of mercury the associated changes in the electrical circuits can be interpreted in terms of the pressure changes. Such information is often essential for the accurate assessment of a patient's haemodynamic status, e.g., measurement of the pressure gradient associated with blood flow through stenotic valves. Also now available are miniaturised transducers which can be incorporated in the exploring end of the catheter to yield direct intracardiac sound or pressure recordings. These are very delicate and expensive, but have many technical advantages over external transducers; for example, pressure records from a chamber of the heart are not distorted by the super-added oscillations of fluid in the catheter and external system which are inevitable with an external manometer. Other techniques are available for use during cardiac catheterisation; these include indicator dilution studies, which involve the injection of an indicator at one site in the cardiovascular system and the recording of its appearance at another. Indicators commonly used are blue or green dyes, hydrogen, ascorbic acid, cold saline and radioactive materials. The site at which the indicator is recorded may be in the systemic or pulmonary circulation or in the cardiac chambers themselves, depending on the particular problem. The use of cold saline is a relatively recent development involving the employment of thermistors (minute temperature sensitive resistors) for recording small temperature changes. These have a particular advantage in that the test can be repeated many times without any deleterious effect on the patient. The same advantage obtains in the use of hydrogen and ascorbic acid, the presence of which can be made to alter the potential of a platinum electrode. Both these techniques use detectors which are easily introduced into the cardiovascular system on the tip of a suitable catheter. The appearance of coloured dye is recorded at suitable sites by means of photo-electric devices placed, for instance, across the lobe of the ear, or in a cuvette through which blood is continuously drawn from the relevant site. The characteristics of the curves thus obtained give much information about the disturbance of haemodynamics; for instance right-to-left or left-to-right shunts within the heart may cause abnormally early appearance or delayed disappearance respectively of an indicator at a peripheral site.

A necessary part of the procedure of cardiac catheterisation is the ability to visualise the position of the catheter. This requires the

use of radio-opaque catheters, or (if the tubing is made of a radio-lucent material such as polyethylene) of a radio-opaque guide wire which is inserted within the catheter. Visualisation is then achieved by the use of X-ray apparatus. In modern equipment the simple fluoroscopic image can be improved by the use of image-intensification; this is achieved by the acceleration of electrons liberated from an object phosphor by high voltage fields in the intensifying tube. The electron beam is focused by magnetic lenses (fields) and caused to impinge on an image phosphor producing a picture many times brighter than the original. This means that the patient can receive lower doses of radiation and that the manoeuvres can be carried out without the need for complete darkness. The intensified image can also be photographed or further brightened, enlarged or modified by closed circuit television.

Angiocardiography consists of the recording of the X-ray image produced following the injection into the heart or vessels of contrast medium, usually an iodinated substance. This is achieved either by using a series of separate exposures, each on a different film, or by the use of cine film which is then projected to give a continuous moving picture of the passage of the contrast medium through the cardiovascular system. Each has its particular advantage in given circumstances, the former being superior if detailed anatomical outline is required, the latter having advantages when the motion and physiology of the heart is being investigated. Such angiocardiographic procedures are nowadays applied to all the chambers of the heart and most of the vessels of the systemic circulation including the coronary arteries, the cerebral arteries and the renal arteries.

These are the procedures which are nowadays frequently used in cardiac diagnosis, which involve electronic techniques.

Therapy

Monitoring. The development of reliable instruments which can display a patient's electrocardiogram continuously on a cathode ray oscilloscope screen now permits much better care of patients at risk from dangerous dysrrhythmias. It is now usual to see monitoring devices at the bedside of patients who have recently suffered a coronary thrombosis, in order to be able to detect and treat at once the arrhythmias which are so common under these circumstances. Following major cardiac surgery it is also the rule to monitor the pressures in the cardiovascular system, such as those in the systemic venous and arterial systems, changes in these being observed immediately and treated accordingly. Inbuilt alarm systems are usually fitted which give warning of any serious change in cardiac rate which may occur, so that resuscitative procedures can be applied immediately when required.

Defibrillation. One of the most striking advances in this field has been the development of electrical defibrillation of the heart. Before its development no method was available for the correction of ventricular fibrillation and when we think back to the days when the only means of achieving atrial defibrillation was the use of prolonged therapy

with toxic drugs such as quinidine, this is indeed a revelation of the power of modern technique. Defibrillation involves the sudden discharge of electrical energy between two electrodes which are placed either directly on the heart (at surgery) or externally on the thorax ("medical defibrillation"). The heart muscle is thus completely depolarised and this is usually followed by resumption of a more favourable cardiac rhythm.

The apparatus may either deliver the energy as a burst of alternating current (lasting about 0.1 sec. i.e., 5 cycles at 50 c.p.s., with an output of 100-900 volts) or as a direct current pulse, the energy being stored before discharge in fairly massive capacitors. In the latter (which is probably the more effective) extensive work has shown that the best way to deliver the energy is as a biphasic pulse of a standard form lasting about 5-10 milliseconds. The electrical energies used vary from 40—500 joules (watt-seconds; 500 watt-seconds is the amount of energy dissipated by a 1 kilowatt electric fire in half a second). The peak voltage momentarily reached between the electrodes during the discharge may be 1,000-2,000 volts.

For atrial defibrillation it is important to time the discharge of the electrical energy correctly for if it occurs during the ascending limb of the T wave it may well induce ventricular fibrillation. The time chosen is just after the R wave of the electrocardiogram and this is arranged by triggering the discharge of the capacitors by the patient's own ECG. This careful timing or "synchronisation" is not necessary if the shock is being applied to correct ventricular fibrillation. The use of ventricular defibrillation, coupled with closed chest cardiac massage and artificial ventilation as soon as warning is given by the monitoring equipment can be expected to save the lives of many patients with recent coronary thrombosis.

Pacemakers. The third relatively recent innovation which has made a great difference particularly to the case of some patients with heart block has been the development of artificial cardiac pacemakers. These deliver rhythmical electrical stimuli (of about 1-10 volts) to the patient's myocardium which initiate ventricular depolarisation and contraction. The heart rate can thus be increased to a suitable level. Electrodes may be sewn to the external surface of the myocardium (the epicardium) for example, at cardiac surgery, as a prophylactic measure in any patient who has suffered heart block during the procedure. Alternatively, and this method is coming to be used more frequently, uni- or bi-polar electrodes can be put into the cavity of the right ventricle and thus into contact with the endocardium by means of a catheter introduced through a peripheral vein. The distal connections of the electrodes (which lie outside the cardiovascular system) are attached to the power unit which delivers the stimuli; this may be external if pacing is expected to be temporary or for a trial period or it may be buried under the subcutaneous tissues, e.g., in the axilla, if required permanently. The use of a pacemaker in a patient suffering from Stokes-Adams attacks may not only abolish his attacks of loss of consciousness, but also increase his cardiac output, with the result that signs and symptoms of heart failure diminish and

the frequency of any existing ventricular arrhythmias decrease (presumably by increasing coronary artery flow).

There are difficulties in the management of patients with pacemakers; for example, fibrosis around epicardial electrodes, infection or rejection of electrodes or leads, and the more obvious problems of power failure, broken leads and displacement of endocardial electrodes. It is also possible that the accident mentioned in the section on atrial defibrillation (i.e. the chance occurrence of a stimulus at a critical time after a spontaneous heart beat) may precipitate ventricular fibrillation. Pacemakers are not therefore the simple answer to the management of heart block, but in spite of these problems, they may save life after cardiac surgery and may transform the lives of others with heart block.

Some interesting work has been done on more sophisticated systems of pacemaking. One of these, atrial pacing, uses the P wave of atrial excitation to trigger (after a suitable delay corresponding approximately to the P–R interval) the stimulus which excites ventricular contraction. This system has the advantage that physiological variations in the discharge rate of the sino-atrial node will be followed by corresponding changes in the ventricular rate, but its increased complexity makes it more liable to fail. Another system, "double pacing" of the ventricle (by stimuli paired so that the second of a pair falls in the relative refractory period of the contraction caused by the first) may be used to try and reduce the rate of ventricular contraction (e.g., in a persistent ventricular tachycardia).

These techniques of intensive monitoring, atrial and ventricular defibrillation and pacemaking have important practical applications. They also show the way to more detailed study of the physiological mechanisms concerned in the heart beat and its regulation, for instance, the contribution of atrial activity to ventricular function.

Information

As in many other branches of medicine, the possibility of introducing computers to analyse information is being extensively investigated. Information may be recorded on magnetic tape either as a discrete number of continuously varying parameters, for example pressure traces or the electrocardiogram, or as recordings of visual pictures on videotape. Computer analysis of this stored information may perhaps be used for given programmes, e.g., the investigation of events which precede serious arrhythmias following myocardial infarctions, or the transformation of pressure traces from paired adjacent catheters into flow signals by means of fairly complex mathematical transformations.

These investigations are in many cases still experimental rather than clinical, but give the promise of introduction into clinical medicine of techniques of diagnostic and therapeutic value.

The majority of the techniques described in this article are used in this hospital's cardiac department.

ACUPUNCTURE

by David Mathias

ACUPUNCTURE or Zhen Jiu is primarily a form of preventive medicine which originated in China at least 1,400 years B.C. In the United Kingdom, in the past five years, there has been a recrudescence of this technique in the treatment of a wide variety of diseases largely as a result of extensive publicity in popular women's journals.

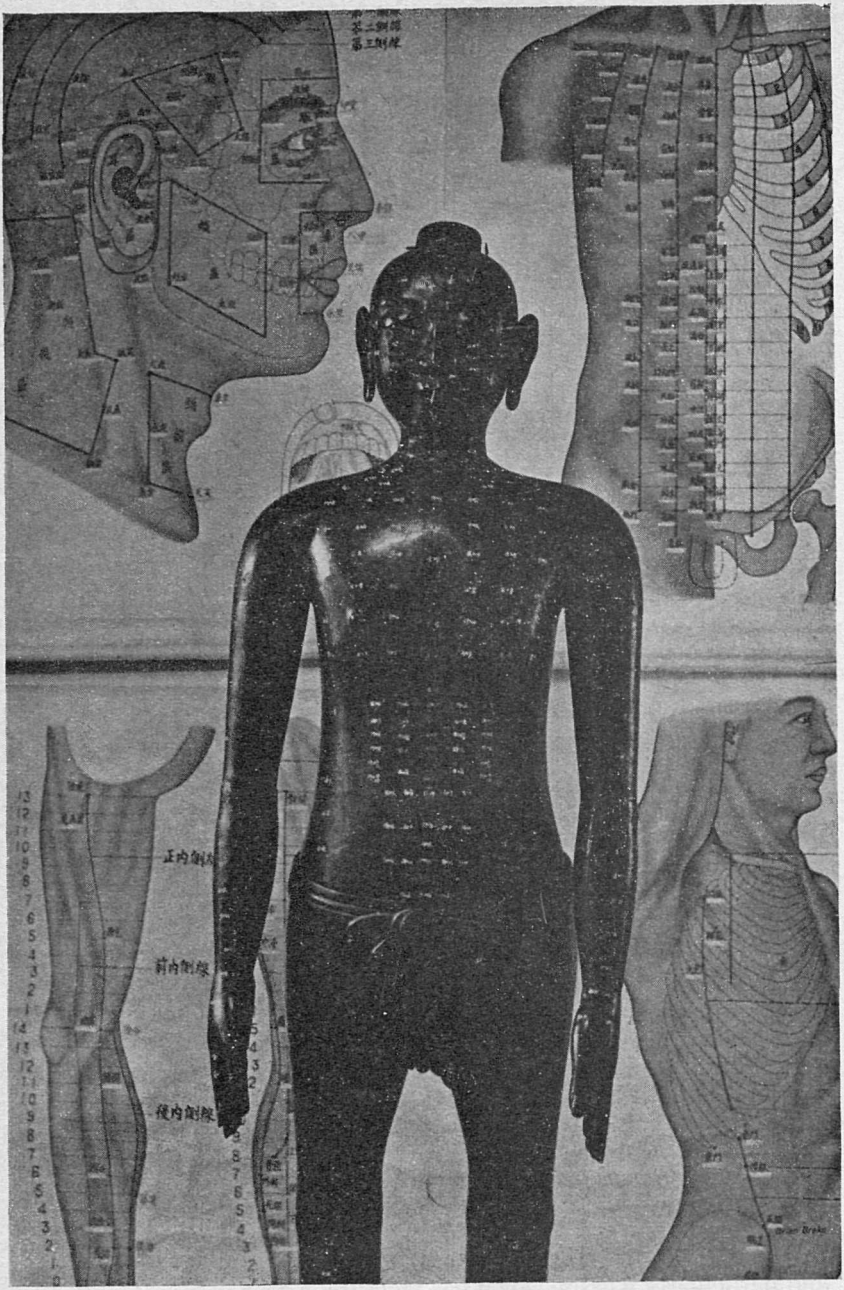
In order to understand the methods of treatment, one must have a basic understanding of the Chinese philosophy from which it arose. The course of nature and all the systems of the universe, are designated Tao. All the regular patterns of nature: day following night, death following life, etc., are grouped under this vast heading, and are thought to be made up of two component parts. These dual forces are termed Yin—the female element, and Yang—the male element. The former is said to represent negativity, the latter positivity. No natural complex can contain only one of these forces, there being a little Yin in every Yang, a concept not entirely divorced from modern psychiatric teaching. Man, being in himself a miniature universe, is subject to identical forces. Thus, just as an earthquake, flood, or similar natural disturbance results from an imbalance in the equilibrium of Yin and Yang, so any disease process is caused by a similar disruption. Separate disease entities are not recognized, rather the instability of Yin and Yang manifesting themselves in one or several of the organs or systems of the body.

These dual forces are conveyed through the body by means of 12 meridians or " Ching Lo." The relative equilibria of these channels may be assessed by palpation of the twelve "pulses" of the wrist. Once any disturbance has been localised, equilibrium is restored by inserting a needle at an appropriate point on that meridian. There are between 365 and 388 of these sites, where the acupuncture should be carried out. The needles, each about two inches long, are made of gold, silver, stainless steel, or even, as the original ones, of flint.

EUROPE.

Interest was first aroused in Europe as the result of attempts by a number of orthodox Japanese physicians in the 1930's to ascertain the mode of action of acupuncture by scientific means. They had no success and reverted to theory of Yin and Yang. The return to France and Germany of the Colonial doctors heralded another upsurge in popularity. With the foundation of the International Society of Acupuncture, in Paris, interest has spread quickly over Western Europe and particularly Russia, which has facilities in four universities.

In the past two decades there have been three relevant discoveries. A German, Weike, while investigating points on the body associated with homœpathetic remedies, discovered that most such points were in



Bronze model used centuries ago for teaching. The statue was covered with wax and filled with water, which spurted out when the right spot was pierced.
(The photograph by Brian Brake was reproduced by kind permission of Magnum Photos.)

close association with the Chinese acupuncture spots. Secondly, a Korean doctor in the early 1950's produced an electrical device for measuring differences in electrical conductivity on the skin surface. He apparently showed that there were a series of "spots" of decreased conductivity which coincided with the areas described by the Chinese. Lastly, Dr. Felix Mann, in his book published in 1962, postulates a series of small "lumps" hitherto not described by anatomists in exact accordance with the acupuncture sites.

MODERN PRACTICE.

The Chinese have, since the revolution, reinstated acupuncture into their health service, and the technique is flourishing in the traditional style. In Europe and the U.S.S.R., new innovations have arisen, and with the advent of the electrical point finder more and more inexperienced people are "climbing on the band wagon." There remain, however, qualified doctors practising in this country and on the Continent, who use the classical methods, but who are perhaps a little aware of their Western medical upbringing.

Reports coming out of China in the past ten years have been strongly flavoured with politics. In 1953, Lu Wei Po and Yu Yung Ching reported the successful control of a Type B epidemic encephalitis with a 95% recovery rate by "traditional" methods. Later reports have appeared of cures in chronic nephritis, bacillary dysentry, tonsillitis, and appendicitis. Both these doctors have Western medical degrees.

The Russians have taken up the challenge and a great deal of work appears to be going on in an attempt to correlate clinical findings with scientific fact. One paper written by Berenbein at the Moscow District Research Unit, describes a series of dermatoses treated by acupuncture in which he reported success in all those with a so-called neurogenic basis. These were listed as neurodermatitis, dermatitis and eczema in association with asthma, and prurigo nodularis.

A paper published in this country by Dr. Felix Mann on the treatment of headache by acupuncture reviews 42 cases. These were carefully selected through the E.N.T. department of St. James' Hospital, Balham, to exclude any known disorder, and treated by orthodox means prior to acupuncture. Of the 42 cases, 32 showed complete or "marked" recovery, some needing follow-up treatment.

Experience at Guy's after a trial of acupuncture in the treatment of cervical spondylosis, rheumatoid arthritis, and lumbar disc lesions, showed it to be of no value in these conditions. However, it has been found useful in the treatment of patients exhibiting hysterical symptoms and associated psychogenic disorders.

CASE REPORT.

A sixty-four year old woman was admitted to Guy's with a diagnosis of myxoedema and rheumatoid arthritis. She had been unable to walk for six weeks.

The myxoedema was brought under control and her arthritis assessed. It was felt that she was capable of walking, and a psychiatric opinion confirmed this to be a hysterical symptom, supposedly arising from difficulty in the home at the time.

Firm attempts to make her walk only resulted in a very haphazard hysterical gait. She was transferred to the Rehabilitation Unit at New Cross Hospital for physiotherapy as an in-patient and subsequently treated by acupuncture. Disposable hypodermic needles were inserted, in random fashion into both legs.

A slight improvement was noticed after the first treatment, and a second attempt was made four days later. The following day her hysterical gait had disappeared, and the patient was walking perfectly well for her age and joint disability.

SUMMARY.

A brief review of the history and modern employment of acupuncture in medical practice is given.

It seems likely that it is of no value in treating organic disease, but may be helpful in psychogenic disorders.

NOTE.—There has been one reported case of the discovery at routine chest X-ray, of acupuncture needles embedded in the chest wall.

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(The author would like to thank Dr. P. H. Kendall for his help in preparing this article.)

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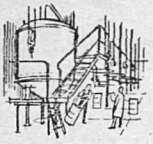

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SIR,

Slapping Pulse

The Eternal Passimist

Yours, etc.

East Wing,
Guy's Hospital, S.E.1.

M. A. Simpson,
Editor of *Pulse*,

The Immune Apparatus

SIR,—In his article, " Some questions and answers," Professor Hunt invites constructive criticism. I would like to take him up on his answer to question 12, which asks " What do you understand by the immune apparatus?" This he defines as "cells synthesising γ-globulins in response to antigens, either exogenous or endogenous"; I believe that this is only partly correct.

" The immune apparatus " is a vague term which could be taken to cover the entire defence system of the body, including epithelia, circulating polymorphs, and such non-specific proteins as the opsonins and interferon. In the context quoted by Professor Hunt, it has a more limited meaning, but surely not so limited as to include only cells synthesising γ-globulins. I feel that a better answer would be to describe the immune apparatus as "cells which on second exposure to exogenous or endogenous antigen show an altered response." This broadens the definition to include those cells which, although they are an integral part of an immune response, do not produce γ-globulins, such as the

macrophages, and the cells of the lymphocytic series which only produce γ-globulins at a certain stage in their development. The essence of this definition is the altered response to a second exposure and it thus excludes those cells which play a part in the defence of the body, but are not part of the immune apparatus in the context quoted by Professor Hunt.

Yours, etc.,

T. CHARD.

Department of Pathology,
Guy's Hospital Medical School,
London Bridge, S.E.1.

[*I was wrong. I am very grateful for the lucid correction.*—Prof. Hunt.]

Disputed Paternity

SIR,—Readers of the general Press may have noticed that on several occasions recently the Bench and the Bar have complimented Dr. Alan Grant, the School's Lecturer in Forensic Serology, on his services to the Law in the field of disputed paternity. This is a field in which Guy's is playing a leading part in this country, and it is to be hoped that the introduction of compulsory blood tests in issues of legitimacy, succession and the like will have the active support of every doctor.

It would be too much, however, to hope that the lay public will have the perspicacity to lend such an advance its whole-hearted support, and to illustrate the kind of opposition it may be necessary to wear down I send you the following letter, received by Dr. Alan Grant.

Repsected Sir,

How could you pssiblely say that a "BLOOD TEST" proves the paternity of a child.
I contradict you, or anyone else who states so.
There is "NO MALE BLOOD" IN ANY NEW BORN BABE.
The blood is solely the mother's.
No blood passes from the male during INTERCOURSE.
Just the "SEMEN" THAT IS ALL. I am afraid the judge has been mistaken, too, in accepeting your find.
Blood Tests are not infallible. No such tests won't hold water. Furthermore, why after THREE YEARS did this take place. His wife is the person who should know whether the child is her husbands or not.
I would be prepared to take her word for it.
I don't think much of her husband.
The case should never have been brought to the court.
It time these nonsenscial BLOOD TESTS WERE STAMPED OUT.
Its a lot of ROT. There is no PROOF whatso ever.

Yours, etc.,

KEITH SIMPSON.

Department of Forensic Medicine,
Guy's Hospital.

NOTICES

Hospitals' Rugby Cup Final, 1966

GUY'S v. ST. THOMAS'S.

The final of the Hospitals Rugby Cup will be played at Richmond Athletic Ground on Thursday, March 3rd, 1966, kick-off 3 p.m. Tickets for reserved stand accommodation (price 4/-) may be obtained on application to Mr. Goodliffe, Appointments Bureau, Guy's Hospital (Ext. 341 and 342) or myself. Unreserved stand accommodation will also be available at Richmond on the day of the match. Applications by post should be accompanied by the correct sum of money and a stamped addressed envelope. Closing date for applications is February 28th.

BRIAN J. ROWLANDS (Hon. Secretary, R.F.C.)

The 59 Club

The Annual Dinner of the 59 Club has been arranged for Saturday, 5th March, 1966. Any member who has not received personal notification should communicate with me as soon as possible. ROGER MAY, *Secretary.*

Annual Clinical Dental Meeting

The Annual Clinical Meeting will take place on March 5th, 1966. The following is the abbreviated programme:

MORNING SESSION (10 a.m.—12 noon).

ANATOMY LECTURE THEATRE, MEDICAL SCHOOL.

11.45 a.m. Lecture: Recurrent Oral Ulceration—Recent Advances and Management. Dr. T. Lehner.

THEATRES Nos. 3 and 4 (FIRST FLOOR, NEW GUY'S HOUSE).

Operations commencing at 10.00 a.m.

There will be Demonstrations and Displays in all the Departmens of the School. Some members of the Visiting Dental Staff will show clinical cases on the Second Floor, Dental Department.

AFTERNOON SESSION (2 p.m.—4 p.m.).

DENTAL LECTURE THEATRE.

2.30 p.m. Lecture: Cases you have sent. Dr. R. A. Cawson.

There will be Demonstrations and Displays in all the Departments of the School. Tea will be served in the Cafeteria, East Wing, Guy's House, at 3.30 p.m.

Programmes giving full details will be available at the Clinical Meeting.

F. S. WARNER,
Dean of Dental Studies.

Guy's Hospital Past and Present Nurses' League

1. *The League Journal.*

All League Members are reminded that a League Journal is now in the process of publication. This should be fully circulated before Easter, 1966.

2. *The Annual General Meeting and Reunion of the League.*

The Annual General Meeting and Reunion of the League will take place on Wednesday, May 11th, 1966. Agendas will be circulated shortly.

3. *The Cosmos and Mabel Bonsor Scholarship.*

The Cosmos and Mabel Bonsor Scholarship for 1966 has been awarded to Miss Myra Calvert, D.N., S.R.N., in order to assist her with finances to be incurred as a student of the Middle Temple. Miss Calvert is at present the Assistant Secretary within the Labour Relations Department of the Royal College of Nursing.

4. *The Nurses' Representative Council.*

The Centenary Meeting of the Nurses' Representative Council was held on Monday, 31st January, 1966. This was inaugurated by Miss M. Hogg, C.B.E., in 1925. A greetings telegram celebrating this significant date in the history of the Council, was despatched to Miss Hogg accordingly.

ANNE M. JOHNSON,
Matron and Hon. Sec. of Guy's Hospital, Past and Present, Nurses' League.

The Psychological Society

The Society met on the 27th January with Dr. J. J. Fleminger in the chair, and was addressed by Dr. J. Willis on " Some Psychological Aspects of Drug Addiction."

Dr. Willis considered in this lecture, among other things, the work of Professor Chein in New York. Some 40 members attended.

On the 24th February at 5.0 p.m., Professor H. J. Eysenck will be speaking to the Society. His subject will be " Measurement of Personality ", and all members of the Hospital are welcome to attend.

G. V. PAY (Secretary).

Debating Society

On Wednesday, 2nd February, we held a debate with the British Railways (Southern Region) Lecture and Debating Society, in the Southwark Cathedral Chapter House, St. Thomas' Street. The motion was: "That a Doctor should be paid more than a Footplateman." Mr. H. C. Lang was Chairman.

There was a good attendance from Guy's; we were particularly glad to see a contingent of Nurses and Physiotherapists. Due no doubt to a signal failure at Bognor Regis, or perhaps iced points in St. Thomas' Street, the 1800 hours debate started at 1809 hours.

The Principle Speaker for the Motion was Dr. A. H. Jones, of the Regional Medical Officer's Department, London Bridge. Dr. Jones emphasised that doctors, especially when newly-qualified, are poorly paid, and can work very long hours. He pointed out, too, the comparative insecurity of the doctor—however hard he works, he has no guarantee of advancement or even employment at the end of each appointment. The Supporting Speaker for the motion was Mr. W. A. Coombs, of the Divisional Manager's Office, South Western Division, Wimbledon, who continued the argument, stressing the lengthy training period of a doctor, and the greater amount of responsibility he has to bear.

The Principal Speaker against the motion was Peter Warren, with Roger Davies as the Supporting Speaker. While the facts of the case left them little ground to argue from, they spoke with great verve, and managed to lay an impenetrable smokescreen of nimble thinking and somewhat acrid wit. There were several railway speakers from the floor—the situation in Cronin's "The Citadel" was cited against the motion; and then its irrelevance to the modern situation was pointed out. Mr. Simpson supported the Opposition to the motion, drawing attention to the vital part played by Footplatemen in the preservation of our national heritage of folklore and customs, and that masterpiece of mystery and imagination, the Railway Timetable.

The Principal Speakers for and against the motion summed up, and the vote was taken. The result was 45 votes for the motion, and 33 against (with a number of abstentions) representing, by the size of the opposition, a considerable achievement by our team.

The debate provided a most enjoyable evening's entertainment, and the Southern Region's Society made us most welcome. Their hospitality, especially to our three speakers, was overwhelming.

It was announced that the Southern Region Society's next meeting would unfortunately have to be cancelled—owing to the proposed rail strike.

M. A. Simpson.

A Symposium on Cosmetic Rhinoplasty

The Plastic Society of Queen Mary's Hospital, Roehampton, are holding a Symposium on Cosmetic Rhinoplasty, on Thursday, 10th March, at 8.0 p.m.

Programme.

1. Mr. Patrick Clarkson (Guy's and Roehampton) in the Chair. Introduction—Nasal Beauty.
2. Mr. Richard Battle (St. Thomas' and Roehampton). Principal Speaker, General Principles.
3. Mr. Henry Elliott Blake (St. George's and Roehampton). The Nasal Tip.
4. Mr. William Holdsworth (Roehampton). The Cleft Palate Nose.
5. Mr. Thomas Faulkner (St. Charles' and Wormwood Scrubbs). The Prison Nose.
6. Mr. Charles McCash (St. James' and Roehampton). Common Difficulties.
7. Mr. A. J. Evans (Roehampton). Psychological Difficulties.
8. Dr. David Carnegie (Guy's). Hypotension or Not?
9. Mr. Philip Reading (Ear, Nose and Throat Department, Guy's). The Health of the Nose in Rhinoplasty.

All Guy's students who care to come would be welcome at Roehampton.

Mr. Patrick Clarkson.

Art Society

A film meeting will be held at 5.30 p.m. on Thursday, 24th February, when the programme will include a colour film on the drawings of Leonardo da Vinci, and an account of the life and work of Van Gogh given by Sir Kenneth Clark.

The meeting is to take place in the Anatomy Theatre. All are welcome.

Bleep!—Residents' Play, 1966

The Play will be running at 8.00 p.m. from Monday, 21st February, to Friday, 25th February, and although seat tickets are hard to get, there is room in the balcony of the Physiology Theatre, and in the gangways for many people. Nurses and students are also welcome at the dress rehearsal on Sunday, 20th February.

REVIEW

HISTOLOGY.

By Arthur W. Ham. Pitman Medical Publishing Co. Ltd., London. Fifth Edition, 1965. Pp. XV + 1041, 666 illustrations.

This is in every way a new edition. Not only has the order of the earlier contents been altered to save space, but the first half of the book has been largely re-written. This has been done to keep abreast of the accelerating volume of new knowledge in cytology. Two new chapters, on nucleus and cytoplasm, have been added to the section on cells. Immunology has received more emphasis, as has correlation between histochemical and biochemical techniques. There has been extensive revision of sections on myeloid, osseous, and muscular tissues.

All these changes have much improved a book which was already one of the best texts in histology, but at the cost of an increase of 100 pages (there are also 77 more illustrations. Incidentally, the magnifications are obviously wrongly stated in several electron micrographs). This increase is important, for it makes this otherwise superb book even more impractical as a continuous text for the average student, and yet it is the author's explicit hope that it will be so used, rather than as a reference book. A little arithmetic will show how vain a hope this is.

Even if a student is lucky enough to have a two-year course in "pre-clinical sciences," he has only 730 days for work, and this ignores all week-ends, feast days, saints' days and other holy-days! Many students in Great Britain have only a five-term course, during which they must cope with texts in topographical anatomy, neurology, embryology, histology, biochemistry, physiology, and also pharmacology in some misguided schools, as well as any extra "subjects" such as statistics, genetics, epidemiology, which local persuasions may heap upon them.

A very good student might possibly do some reading on 500 days during the whole course. If he uses books of the size of Gray, Ham, Hamilton's Embryology, and so on, he will be undertaking at least 3-4,000 pages of reading in Anatomy alone. Other subjects will at least double this, giving a burden of perhaps 15-20 pages of new reading on each of 500 separate days. This makes no allowance whatsoever for revision or any desirable avocational reading. Sickness is unthinkable!

The situation has indeed become absurd. Even the best students are likely to be submerged by the deluge of printed words. In the event most find much smaller books, and unfortunately they are commonly by lesser authorities. We *must* have shorter texts by the best men. I would not recommend any other book than Ham's to my students—if it were only less than half its present size.

ROGER WARWICK.

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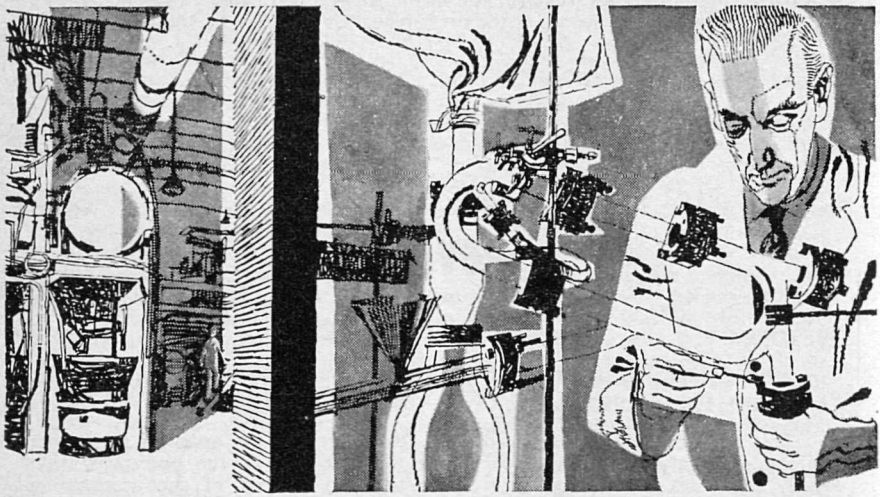

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SPORT

Guy's For The Cup!

Guy's for the Cup. For the past five years these traditional words have been uttered annually to no great effect, for Guy's have failed to reach the final since their very successful appearance of 1961. The 1st XV, having already proved themselves far stronger than those of recent years, now find themselves on the threshold of achieving this goal, for on Tuesday, February 8th, they handsomely defeated Charing Cross 18—5, thereby gaining a place in the final to meet either St. Thomas's. This side will provide stiff opposition, so that neither finalist will travel to Richmond on March 3rd as the accepted firm " favourite." The Hospital may, however, rely on an " all-out " performance from a very dedicated team, and the team may rely on the equally enthusiastic support of the Hospital.

The Rugby Club's hopes to " do the double " this year have been further reinforced by the A XV's victory over The London 14—5 in the second round of the Junior Cup. Middlesex Hospital provide the challenge in the semi-final to take place on Wednesday, February 16th.

In their last two Saturday fixtures the 1st XV have produced two more fine performances. In the first they held a strong Coventry side to 15—6, and in the second they defeated Oxford 11—0. In the latter, S. Horsley, a freshman, capped the impressive record he has forged already in the A XV with a very creditable debut.

Since our last edition the England selectors have announecd the national side to play Ireland. That encounter now having taken place, we must congratulate W. T. Treadwell, the Guy's hooker of four seasons ago, on his new status. We wish him well in his future international career.

The Hockey Club have suffered unkindly from the new rules they themselves caused to come about as a result of their repeatedly drawn games with Bart's last season. It was agreed that there should be a limit of one re-play in the event of a draw, and that the issue should then be decided on corners if good equality continued. Needless to say, Guy's came up against Bart's again this year, and after the regulation re-play and extra time, Bart's scraped home by a short corner. Two other enjoyable and successful games against the National Provincial Bank and Walton-on-Thames, when Guy's won 4—3 and drew 1—1 respectively, are reported below.

The recent dominance of Rugby news in the sports section of the *Gazette* is beginning to cause the Sports Editor a little embarrassment. Contributions from the other Clubs are respectfully invited, preferably to be received more than five minutes before the *Gazette* goes to press.

DIARY

Feb. 19.—Rugby v. London Irish. Away.
Hockey v. Queen's College, Cambridge. Home (10.45 a.m.).
Football v. Jesus College. Away.
Cross-Country Hyde Park Road Relay—Hyde Park.
,, 22.—Squash v. H.A.C. Home.
,, 23.—Football v. Charing Cross (U.H.L.). Away.
Cross-Country Div. I League Race—Richmond.
,, 24.—Squash v. Sundridge Park. Away.
,, 26.—Rugby v. Exeter. Away.
Hockey v. Sevenoaks. Home.
Cross-Country U.H. v. Cambridge University—Cambridge.
Mar. 2.—Football v. Varndeen G.S. A.
,, 3.—Rugby. Final, Hospitals Cup—Richmond.
Squash v. Beckenham. Home.

REPORTS & RESULTS

RUGBY

Hospitals' Cup Semi-final
GUY'S v. CHARING CROSS HOSPITAL
February 8th, 1966
Result: won 18—5

Guy's accounted for Charing Cross Hospital with some ease in the semi-final of the Hospitals' Cup at Richmond, and now go forward to the final of the competition when they will meet either St. Thomas's or St. Mary's on March 3rd.

It was the Guy's forwards who took the laurels in this game as they did against the London Hospital two week's previously. After the first quarter, when they allowed themselves to get involved in senseless mauls, they really got down to the job in hand, and as the game advanced, took control of all aspects of forward play. They fed their backs with monotonous possession from the line-outs and set pieces, particularly in the last quarter of the game, and altogether they looked much stronger compared to their opponents. In fact, it was a notable feature that Hey, with splendid support from his props, was able to achieve fourteen heels against the head during the course of the match. Davies once again was an ideal captain and a tower of strength in the front row. Cockburn, Peace and Kingdon excelled in the line-out while Sharp and Thorburn were everywhere in defence and attack. Sharp in particular had a really splendid game and scored a good try at a vital stage of the game. With such possession one is left to speculate why the final score was not more in our favour. This must surely be due to the fact that there is still some weakness at half back where Swift, although playing brilliantly in defence, again showed hesitation at times in getting the ball away; Rowlands, despite his brilliant cut through in the first half, kicked far too often when in an attacking position, and was frequently caught in possession. It is imperative that our wings are brought more into the game in the next match, and this can only be achieved by quicker thought and action at half-back. Lindsey and Edgar handled well when given opportunities and they were both sound in defence. Morgan took his scoring chance excellently, while Bundred was an adequate substitute for Ross. Elliott was safe at full-back but had an off day with his goal kicking.

Exchanges were even in the first quarter and during this period Elliott had two shots at goal from long distance without success. Guy's tried hard to attack but were kept in check by good defensive covering from Charing Cross. After twelve minutes, Guy's opened their account when Rowlands, after receiving a beautiful pass from Swift, made a brilliant outside break and passed the ball to Edgar, who transferred to Morgan, who ran in to score from twenty-five yards; Elliott failed to convert. Following this score, Charing Cross roused themselves to greater efforts and initiated one or two good threequarter movements but were held back by sound defence, particularly by Swift and Elliott. Guy's eventually worked their way back, and following a scrum infringement, Elliott increased the lead with a well taken penalty goal from thirty-five yards against the wind.

Despite these reverses, Charing Cross fought back splendidly and they were unlucky not to score when Elliott misfielded and a Guy's defender just got back in time to touch down and prevent a score. However, a few minutes later their fly-half made a sudden switch of direction by running to his right and then kicked towards the posts on his left where the ball was misfielded by Bundred as a result of which the wing scored in the corner. The try was converted from a wide angle.

Guy's fought back strongly after this score and Elliott was just wide with another penalty, and Rowlands made another good break which nearly resulted in a score by Bundred. It was clear that Guy's had been knocked out of their stride to some extent during the first half by the spirit and fire of the opposition, but the interval arrived with the Guy's forwards firmly in command of the situation.

Guy's began to look dangerous early in the second half and the play was mostly in their opponents' half of the field. After ten minutes, Lindsey made an excellent break but was finally grounded, whereupon Rowlands picked up the loose ball and gave it to Sharp who was running through at speed, and he scored in the corner. Elliott failed to convert. This score seemed to act as a tonic, for within five minutes Guy's scored again. It began with a good three-quarter movement which was followed by a beautifully placed high kick ahead by Edgar, which had the Charing Cross full-back in difficulties. The latter was caught in possession by Cockburn and the loose ball was picked up by Thorburn who ran in from ten yards to score near the posts. Elliott again failed to convert.

At this stage of the game Guy's were well on top of their opponents and the backs were having a monopoly of the ball from the line-out and set scrums. Following a series of attacks, which were splendidly repelled by Charing Cross, Elliott kicked a well judged penalty goal from twenty yards for an infringement in the scrum. Finally, Hey finished off a good afternoon's work when he burst through from the front of the line-out and ran with great speed and determination to score in the corner. Elliott missed a difficult conversion.

In summary, there is enough potential in this side to bring back the Cup for the first time since 1961, when we beat St. Thomas's in the final.

Team: D. R. Elliott; P. E. Bundred, M. Lindsey, J. A. Edgar, I. J. Morgan; B. J. Rowlands, P. G. F. Swift; J. E. Davies (Capt.), G. B. Hey, R. Stansfield, A. J. Kingdon, P. K. Peace, H. C. Sharp, J. M. Cockburn, C. W. Thorburn.

J. D. CARROLL

Junior Hospital Cup 2nd Round

GUY'S "A" *v.* LONDON "A"

Hale End 3rd February, 1966

The "A" XV were back in their winning role against London Hospital, following their unfortunate lapse against Wimbledon the previous week.

Conditions were not easy, with a blustering wind and heavy pitch. Nevertheless, the "A" settled down quickly, the pack winning more than their fair share of the ball. There was a marked increase in possession from the loose play, thanks to the return of Hendrick, C. Neville and E. Neville.

The first score came after 10 minutes, when the London were penalised on their 25 yard line almost in front of the posts. A. M. Morris, the Guy's full-back, had no difficulty with the kick.

For the remainder of the first half Guy's were in command, but seemed unable to convert their superiority into points. Possession was gained from the set-scrums due to the combined work of a good front row, and from the line-out, due to the jumping of C. Neville.

In the threequarters, Cheeseborough made several good runs, but unfortunately delayed or dropped passes made nothing of scoring chances. Once, at least, a try was missed because an overlap was ignored.

However, Guy's increased their lead to six points before half-time, again through the fine goal kicking of A. Morris.

In the second half Guy's continued to press, and the London defence, which had done so well in the first half, eventually broke down. A fine passing movement, involving many members of the side, was completed when C. Doyle crossed the line to touch down near the posts. Morris added the extra points with another good kick.

Shortly afterwards Guy's scored again; this time through Curzon. This was a just reward for his relentless backing up, he took an inside pass from Cheesborough, out ran the defence and scored wide out. Morris failed narrowly with the conversion.

At this stage of the game Guy's, with a lead of 14 points, suddenly eased up and allowed London to come back into the game. For a full twenty minutes London began to get possession from the loose play, and mounted several attacks. It was only good tackling by the back row and the threequarters which prevented a score. Horsley in particular saved several difficult situations with spectacular tackles. Eventually, however, London managed to score a try which was as much a result of hesitancy in falling on the ball as it was of the speed of the London following up.

This try seemed to remind the Guy's team what was at stake, and although they did not score again, their efforts contained the London in their own half for the rest of the game. A similar lapse against better opposition could have cost Guy's the game and the chance of retaining the Junior Cup.

Team: A. Morris; P. Bundred, R. Beacham, S. Horsley, G. Thomas; M. Cheesborough, B. Moore; E. Neville, C. Lewis, A. Forbes, K. Brown, C. Neville, C. Doyle, D. Hendrick (capt.), D. Curzon.

D. OSBORNE

GUY'S *v.* COVENTRY

At H.O.P. Saturday, 5th February, 1966

Result: lost 6—15

Coventry brought a very strong side down to H.O.P. with only five of their regular first team players absent. Unfortunately, Guy's, too, were below strength with five of the Cup side unable to play. Conditions were miserable for this game with a stiff wind blowing the drizzling rain straight down the pitch. Guy's, having played a poor first half against the elements, did well to hold Coventry in the second half. Coventry won by five tries to a try and a dropped-goal.

Coventry kicked off with the wind at their backs into the Guy's half where they remained almost until half-time. The initial set pieces produced clean possession for the Coventry threequarters, who soon gave us a fine display of handling and running in really appalling conditions. It was only after 10 minutes of play that Coventry heeled against the head, and after changing the direction of attack, sent their left-winger over for a try in the corner. In spite of the occasional good attempt, Guy's tackling at this stage of the game was very poor and consequently Coventry were allowed three more tries before half-time. Guy's were not just struggling against the strong wind and the rain in the first half, they submitted to an overpowering lethargy in almost all that they attempted to do. The only aspect of Guy's play that looked at all fiery was Hey's heeling from the tight which was so effective that on many occasions Swift had to run back several yards to retrieve the ball, enabling his opposite number to catch him in possession. The half-time score was therefore 0—12.

Davies obviously rallied his pack well at half-time, because at the resumption of play we saw a much more determined effort. In fact, Coventry only scored once more, and then it was Guy's turn to put the pressure on and retaliate through Elliott. Coventry were penalised, and Elliott was called to take the 35 yards, slightly angled, kick at goal. He made a fine attempt but the ball hit the left upright and bounced back into play. Elliott followed up, dribbled the ball over to score a try near the corner. In the next 15 minutes, Guy's made several useful raids into Coventry's half, but worthy of note are Bundred's break on the right wing which he completed with a superbly placed cross-kick, and shortly afterwards Rowlands made a gorgeous outside break from well inside his own half and took play to Coventry's twenty-five line. Guy's now kept play near the Coventry line for some while and the tight forwards were beginning to assert themselves. Soon a high kick from Coventry was directed at Elliott, who struggled to control the sodden ball, but recovered in time to score a fine drop-goal from about 35 yards out.

This was the end of the scoring, but Guy's fought on well until the final whistle. When are the Guy's team going to play flat out for 80 minutes instead of leaving it all until the last 30 minutes of each game?

P. K. PEACE

HOCKEY

Hockey Cup 2nd Round Replay

GUY'S v. BART'S

Wednesday, 2nd February, 1966

Result: lost by 1 short corner

In the replay of the quarter-final of the Inter-Hospital Hockey Cup, Guy's were very unlucky to be knocked out by Bart's, at Chislehurst, in what was one of the best games of the season.

The game started at a very fast and hard pace, and this was maintained to the end. In the first half Guy's played well and looked most dangerous, but a very good Bart's defence ensured that at half-time the score should be 0—0.

In the second half M. Appleby and D. Steer changed positions in the forward line to good effect. Some of the best movements of the season resulted and eventually a good pass found M. Appleby, who beat his "shadow" defender to score a brilliant goal. During the next ten minutes the two teams showed even more determination, and C. Pearson had his hand crushed in a desperate tackle, while a Bart's forward retired with a pulled muscle. Shortly before full-time the Bart's left wing was able to score the equaliser after a lapse in the Guy's defence.

In the previous season Guy's were eliminated by Bart's after one game, two replays and two lots of extra time, in which only three goals were scored. As a result the Cup rules were amended. Thus, in the event of a draw after the end of a replay and extra time, the team awarded the most penalty flicks, short corners or long corners respectively, goes through to the next round.

With this in mind, Guy's started the first period of extra time a long corner in the lead. At the end of this period the lead was now one short corner. Then, four minutes from the end, Bart's threw everything into attack, bringing their Welsh International up as an attacking centre-half, and soon were awarded two short corners one after the other to put them in the lead by one short corner, for the first time. In the remaining minutes Guy's tried to clinch the game with a desperate effort but could not get into the opponents' circle!

The Hockey team greatly appreciated the large number of people who supported the team both during the game and afterwards in the pavilion.

Guy's team: S. Rear; R. Kendrick, M. Vellacott, J. Crafts, C. Brooks (Capt.), R. Lallemand; S. Cripps, D. Steer, M. Appleby, P. Brown, C. Pearson.

C. A. BROOKS

GUY'S v. N.P. BANK

At H.O.P. 5th February, 1966

Result: won 4—3

A full Cup team played an enjoyable game in which some good movements resulted in Guy's being 2—1 up at half-time. The first goal was well taken by P. Brown, and the second from a short corner. During the second half light rain fell, but did not affect the tempo of the game. M. Appleby, winning the bully-off, successfully dribbled the ball to the opposing circle to score a brilliant individual goal before an opponent could take the ball from him. Ten minutes later D. Steer scored the fourth goal, which seemed to rouse the Bank team into greater effort. This brought two goals, one of which was due to an unnecessary lapse in the Guy's defence. After the game the opposition stayed on to enjoy a game of "Clap Claps", the beer for which was provided for by a generous donation of the N.P. Bank Club President.

C. A. BROOKS

GUY'S v. WALTON ON THAMES

Result: drew 1—1

Last Saturday, 12th February, a weakened forward line faced Walton on Thames, who had only lost one game this season. The game started at a very fast pace and Guy's moved the ball well, and had two good chances to score. The latter was hammered in the net by Alan Brooks. The defence played well, and Walton could not settle down. However, in the second half the Guy's defence were progressively hard pressed and gave away numerous short corners, one of which resulted in a goal to Walton. Although Guy's had one or two more chances, the game ended in a draw.

The team is playing very hard and well considering the recent dissappointment of being knocked out of the Hospitals' Cup.

C. A. BROOKS

ASSOCIATION FOOTBALL

U.H. Cup Round II

GUY'S v. CHARING CROSS

Away. Saturday, 12th February, 1966

Result: won 3—1

This was a match which indicated that, despite setbacks earlier this season, Guy's soccer is on its way to the top of Hospital soccer; for our opponents are at present leading in the U.H. League.

The match started evenly, with each side probing the other's strength. The heavy pitch was miserably cut up into lumps of mud before a long pass from Jacobs, the left wing, eluded three Charing Cross defenders to reach Powell-Jackson who coolly pushed it into the net. This goal put desperation into a surprised Charing Cross, whose menacing attacks were neutralised by the hard tackling and concerted covering up of the Guy's defence. Brander and Nash featured well in the rear game, using their wings superbly.

Shortly before half-time, Ward, collecting a loose ball and running with it, found Elias with a diagonal back pass that was hit first time to make the score 2—0.

The beginning of the second half saw Charing Cross more in the game. There was near panic in the Guy's goalmouth as a Charing Cross forward, always nimble, always dangerous, missed by a hair's breadth with a hard shot. Later, Elias tore away in a solo run before driving the ball low past a displaced goalkeeper. Just before the end of the game, Charing Cross, in one of their many probes, found luck in a silly mistake by Guy's to reduce the score to 3—1.

This match was won by team effort and sees Guy's through to the semi-final against Middlesex on Saturday, 26th February. We need your support.

Team: D. Lindridge; R. Billings, W. Brander; S. Poole, R. Davey, I. Nash; M. Anto, E. Elias, J. Powell-Jackson, D. Jacobs.

MANFRED ANTO

CROSS-COUNTRY CLUB

On Wednesday, 2nd February, a Guy's team went to Hyde Park at the invitation of St. Mary's Hospital, to run in a five mile road race for the Sir Arthur Porrit Cup. Thirty-six runners from five London Hospitals started, and the pace of running and heat of the afternoon hinted at the marathon event. Because they only had one runner in the first ten home, Guy's were beaten into third place behind Bart's and the London Hospital. Dr. Bannister presented the cup at the tea afterwards.

6, B. Smith; 13, R. Wilson; 20, B. Avery; 21, D. Halestamp; 22, E. Bowen-Jones; 31, M. Henry and R. Ibbotson.

The new U.H. course at Chingford is probably one of the most unashamed Cross-Country courses that we have to run over. Its six miles provide a mile of continuously deep swampy mud, a long gruelling hill, a lot of varied country, and a fast run in at the finish. On Saturday, 5th February, Bowen-Jones, Wilson, Avery and Hey ran in a U.H. home team match against Oxford Tortoises. The Flanders-like conditions did not prevent the Oxford men from packing well and beating U.H. by 35 to 43 points.

Last Wednesday, 9th February, we had a quadrangular match over five and a half miles of the L.S.E. course at Parliament Hill Fields. Our opponents were King's College, L.S.E. and St. Mary's College, Twickenham. The afternoon was so wet and cold that we seriously considered deciding the result at the changing rooms. The full results have not yet been circulated, but at least one of the Guy's eight finished and lived to tell the tale.

R. M. WILSON

BOXING

GUY'S v. CAMBRIDGE UNIVERSITY

Pavy Gym. 1st February, 1966

Result: lost 5—4

In one of the finest boxing shows seen at Guy's for some years, Guy's were narrowly beaten by a Cambridge University team consisting largely of boxers due to fight in the Oxford v. Cambridge match in March. To lose by just the odd bout in nine was an excellent performance which bodes well for the future of boxing at Guy's.

In the first bout of the evening D. King, of Guy's, in only his second fight, proved far too good for his opponent, whom he stopped in the 1st round, after delivering a perfect left hook to stop his unfortunate foe dead in his tracks.

Both K. Hughes and D. Edgar met with rather stronger Cambridge resistance, being stopped in the second and third rounds respectively. Hughes, in particular, who took counts of eight, eight and three, found himself up against a stronger and fitter opponent.

J. Crawford, who lost the next bout on points, might have taken the decision had he not appeared to be carefully pacing himself for a fifteen round contest. Only in the last minute of the bout did he finally show any true aggression.

T. Gibson, appearing for the last time in Guy's colours, won an excellent bout on points against his equally skilful opponent. He has given great service to the Club and will be greatly missed in future matches.

A perfect left hook in the first round ended the hopes of B. Hartley in the next contest, and with the match score at Guy's 2, Cambs. 4, the prospects of winning the match looked thin.

However, we were then treated to as exciting a heavyweight contest as anyone would wish to see. R. Stansfield, at 13½ stone, and conceding two stone to his Cambridge opponent, charged in from the opening bell, and in spite of frenzied resistance from the Cambridge man, and having to take a count of eight in the final round, won an excellent points decision.

Unfortunately, this was not enough to give Guy's the match, since T. Craig, of Guy's, found his Cambridge opponent a little too strong and lost a points decision.

In the last contest of the evening, W. Onyeama, the Guy's Captain, narrowed the final score by stopping his opponent with a succession of left hooks in the third round.

A very large and very vocal audience showed that there is no lack of support for the Boxing Club, and the evening was clearly enjoyed by all those present.

A. L. STANHOPE

BOAT CLUB

The Boat Club has been active at Chiswick from the beginning of term. Training is going on for the long races at the end of term known as the "Head of the River Races". This time of year is by tradition the low point of Guy's rowing, so that we can be pleased to be able to put three eights on the river, a record for many years. Rowing suffers badly from individual absence through 'flu, so we are hoping that the present epidemic will not be too severe.

Our fixtures for the term are as follows:—
Saturday, March 5th—Bedford Head.
Saturday, March 12th—Reading Head.
Wednesday, March 16th—University of London Head.
*Saturday, March 19th—Tideway Head.

*This takes place over the boat-race course. More than 300 crews are expected; a fine sight!

All races are in the afternoons, and support is never amiss, especially from old oarsmen.

J. WILLIAMS

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Research Associate (Lecturer status) in the Department of Surgery,** to engage in clinical work and research projects in the breast clinic; duties to commence as soon as possible. Salary in the range of £1,580 to £2,150, with superannuation. Forms of application are obtainable from, and should be lodged with, the Dean, not later than **28th February, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Orthopaedic and Casualty Registrar,** with duties commencing as soon as possible, and appointment until 30th September, in the first instance. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **22nd February, 1966.**

GREENWICH DISTRICT HOSPITAL, MILLER GENERAL WING

Senior House Officer in Pathology (with some duties on medical side) required for duties in the Group. Post recognised for D.Path examination of Conjoint Board. Resident or non-resident. Suitable for candidate reading for higher degree wishing to obtain Laboratory experience. Salary £1,195/£1,255 according to age. Applications, stating age and qualifications, with names of two referees to Group Secretary, G. & D. H.M.C., St. Alfere's Wing of the above Hospital, Vanbrugh Hill, Greenwich, S.E.10, by **3rd March.**

BEXLEY H.M.C.

DARTFORD H.M.C.

Senior House Officer in Psychiatry required. Single and, possibly married accommodation available. Duties will be at the Psychiatric Unit, West Hill Hospital, Dartford, for six months and at Bexley Hospital for six months by interchange with a similar post. The Hospitals are 17 and 14 miles respectively from London, and there are good travelling facilities.

The Psychiatric Unit has 51 Inpatient beds, Day Hospital facilities and Outpatient Clinics.

Bexley Hospital has over 1,900 beds dealing with all types of psychiatric illness. The post offers experience in modern, physical, occupational and psychotherapeutic procedures and community care.

Clinical Instructions, Tutorials in Psychology given and facilities exist for attending D.P.M. Courses. The post is recognised for D.P.M.

Hospitals may be visited by arrangement.

Application, giving two referees, to Physician Superintendent, Bexley H.M.C., Bexley Hospital, Dartford Heath, Bexley, Kent, within ten days.

PASS LIST

CONJOINT BOARD

Final L.R.C.P., M.R.C.S.

Pathology

Bramwell, R. S. B.	*Govan, J. R.
D'Souza, M. F.	Rumpus, M. F.

Midwifery

*Bevan, D. R.	Machin, G. A.
Bevan-Jones, A. B.	O'Donnell, A. J.
Brummitt, J. M.	*Pietroni, P. C.
Collins, J. V.	Powell-Jackson, J. D.
Dussek, J. E.	Ratcliffe, G. E.
Herrington, M. R.	Sawyer, D. H.
*Jamil, M. A. Q.	Sturzaker, H. G.
Johnson, D. A. N.	Valentine, B. H.
*Letanka, S. E.	*Watson, C. J.

Medicine

Ashcroft, P. B.	Landon, K.
Brumitt, J. M.	Lansdowne, J. D.
Byer, L. D.	Machin, G. A.
Collins, J. V.	O'Donnell, A. J.
Cressall, J. E. M.	Powell-Jackson, J. D.
D'Souza, M. F.	Ramage, R. J. V.
Dussek, J. E.	Ratcliffe, G. E.
Gill, J. R.	Sawyer, D. H.
Herrington, M. R.	Sharpe, J. R. C.
Hine, I. P.	Sturzaker, H. G.
Hughes, P. S.	Wardle, D. F. H.
Johnson, D. A. N.	Whitfield, Diana J.

Surgery

*Anto, M. K.	*Parfitt, G. G.
*Bayley, I. J. L.	*Peace, P. K.
*Cunningham, Mary T.	*Pickering, C. A. C.
*Dunn, K. N.	*Pietroni, Theresa D.
*Evans, D. P.	*Raynes, A. E.
*Gareeboo, H.	*Rees, H. E. G.
*Gibson, T. J.	*Rhodes, D. J.
*Govan, J. R.	*Rickard-Bell, Lyall M.
*Guerrier, T. H.	*Roe, T.
*Hale, Helen	Rumpus, M. F.
*Hendrick, D. J.	*Rushforth, G. F.
*Higgs, F. D.	Rushmer, P. J.
*Jourdan, M. H.	*Searle, J. F.
*Joyce, M. R. L.	*Siggers, D. C.
*Kramer, Susan L.	*Smith, G.
*Lawrence, Joy S.	*Spurrell, R. A. J.
*Leiberman, D. P.	*Stanhope, A. L.
*McCall, S.O'D.	*Stannard, Clare E.
*Malpass, C. P.	*Stephen, Isobel M. J.
*Masters, D. K.	*Taylor, G. A. W.
*Mathias, D. B.	*Tong, D.
*Mowbray, Carolyn J.	*Underwood, T. D. P.
*Newman, C. L.	*Watson, C. J.
*Nicholson, J. A.	*Williams, T. L. S.
*Oei, B. E.	

*Have completed the examination.

Corrections to Pass List published in Gazette of February 5th.

Final B.D.S.

Pass

E. W. Blackwell

T. J. Storrs was awarded honours in General Surgery, not Bacteriology and Pathology.

PERSONAL

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CHANGES OF ADDRESS

Dr. and Mrs. H. Malcolm Tuddenham, to "Fermain", 30, Osborne Road, New Milton, Hants. Telephone No. New Milton 2554.

Dr. and Mrs. J. T. N. Williams, to 19, Somerleyton Avenue, Kidderminster, Worcs. Telephone No. Kidderminster 2822.

Dr. R. A. J. Webb, to Gladesville Hospital, Gladesville, N.S.W., Australia.

BIRTHS

SMITH.—On January 18th, in Crawley Hospital, to Felicity (née Hamilton-Miller) and Dr. Dennis Smith, a sister for Fiona and Rachel.

DAVIES.—On May 28th, 1965, at the Montreal General Hospital, to Peter and Kathleen (née Hopkins, S.R.N.) a second daughter, Heather Lynne.

COPLEY.—On December 27th, 1965, at Quarry Bank, Graigwen, Pontypridd, to Faith (née Mundy, S.R.N.) and Brian Copley, M.B., B.S., a daughter, Alison Claire, a sister for Graham and Sarah.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

DEATHS

KINGSTON.—On 8th February, 1966, at a Southbourne Nursing Home, after a short illness, John Waldron Kingston, L.D.S., R.C.S.(Eng.), of E32, San Remo Towers, Boscombe, and 104, Southbourne Road, Southbourne, Bournemouth, dearly beloved husband of Grace and dear brother of Violet.

LEDLIE.—On January 18th, 1966, suddenly, Reginald Cyril Bell Ledlie, F.R.C.S.Eng., M.B., B.S., aged 68 years.

HASKINS.—Charlotte, M.V.O., R.R.C., died on 24th November, 1965, aged 67 years. Trained in the Guy's Hospital School of Nursing 1921—1924.

SPARKES.—Marjorie Woodman, died on 29th December, 1966, aged 74 years. Miss Sparkes trained in the Guy's Hospital School of Nursing 1914—1918. She was in charge of the Midwifery Department of the Middlesex Hospital 1921—1937, and then the Matron of the Royal Maternity Hospital, Belfast, 1937—1951.

SPALDING.—On February 4th, 1966, at his home, 141, Bath Road, Worcs., Frederick Lionel Spalding, M.D., F.R.C.S.Ed., M.R.C.S., L.R.C.P., aged 80 years. Honorary Freeman of the City of Worcester, the most dearly loved husband of Ines and father of Richard and Rosemary.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2024

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PASSIM

Brain Strain

If Darwinian theory is still applicable to our present civilisation, and man dominates because he is relatively unspecialized physically and superior mentally, then survival will depend on control of his environment. One effect medicine has in this evolutionary process is that it is increasingly preserving genes which would otherwise be eliminated. It could be argued that this may prove to be an insupportable departure from nature's selection but as selection takes place against a background of environment and medicine can be considered as part of this, then perhaps we are still within the limits of Darwinian theory.

However, there are many areas of existence in which man is becoming unsuitable to its own manipulated environment. The mere act of living and working in London demands relatively highly developed qualities in man. The stresses are large and growing. The casualties from this developing social complexity are increasing. One in five of all hospital beds are filled by psychiatric patients.

Society is beginning to seek solutions to these problems, but the facts are obscure, enlightenment is slow and the changes difficult to accept. For example, within months of producing its first report, the Brain Committee was panicked into producing yet another, only to provide recommendations as dubious as the statistics contained in its first publication.

It would appear that one of the prices of present civilisation is to increase the stresses of everyday life and then step up demands made by society on psychiatrists and psychologists. They will be expected to produce answers. But although psychiatric research over the last thirty years has been prolific, the aetiology of psychiatric disorders remain speculative, their pathogenesis obscure, their treatment empirical. As a scientific discipline it is still in its childhood, but its results show that it is a precocious child. Its later sophistication may yet prove to be an enormous step towards a better adaptation to our environment and a more secure preservation of our species.

Over the next few months the *Gazette* will be publishing a series of articles on psychiatry. With this we shall endeavour to present a picture of some of the facets of psychiatry, its practice and research which is being carried out at the present time.

Educational Methodology

The present trend in answering the problems of education seems to be towards an open, fluid attitude that is empirical and undogmatic, reflecting that, to-day, perhaps more than ever before, rapid changes in almost every aspect of our way of life are at least anticipated, if not so often welcomed.

The word Education has itself been long involved in semantic and etymological controversy. However, the distinction that is popularly drawn between the educator proper and the simple teacher is that the former endeavours to help his pupil to think for himself, whereas the latter merely imparts information.

In this respect our current concept of Education is a very wide one that stretches beyond our schools and universities. It is a process that, far from being merely a preparation for life, is a part of living itself. However, the concern of the present age is mainly with the formal institutions of Education and here the questions are what should they teach and how should they teach it.

With the formation of organised staff-student liaison we have acquired a potentially very interesting additional aid for attempting to solve at least the latter part of this problem. For the students to be able to communicate to their teachers more directly either that one particular system is of value or another a mutual waste of time, would appear to be a more logical means of working out an educational methodology and also an encouragement in itself for students to think. The really effective working of such a feed-back mechanism, however, presupposes that the students concerned are interested, articulate and capable of reflection at such close quarters. It will be interesting to see if the Guy's Medical Education Committee, now nearly a year old, and coming up for re-election, will be able to do such a job in the future.

GUY'S DIARY

MARCH.

Exhibition.			Obstructive Jaundice.
7th—11th			Art Society Exhibition, Gordon Museum.
7th	M.	1.00	Clinical Lecture. Mr. BLACKBURN. "On Examiners and Examinations".
8th	Tu.	1.00	Clinical Lecture. Mr. BEARD. "Torsion of the Testis".
11th	Fr.	1.00	Clinical Lecture. Mr. BRAIN. "Pre-Cancerous Pathology of the Oesophagus".
		1.00	Clinical Lecture to Dental Students in the Dental Theatre. Dr. M. N. NAYLOR, "The Clinical Trial".
		2.15	Combined Round. Professor TROUNCE and Dr. BISHOP.
12th	S.	10.00	Departmental Round: Will be conducted by Professor J. G. MURRAY, of King's College Hospital Medical School.
15th	Tu.	1.00	Clinical Lecture. Professor HUNT. "The Regulation of Gastric Emptying and its Clinical Implication".
17th	Th.	1.00	Clinical Lecture. Dr. HARDWICK. "Thomas Hodgkin, 1797–1866".
17th	Th.	5.00	Neurosurgical Round: Will be conducted by Mr. SHURR, in the Clinical Theatre.
18th	Fr.	1.00	Clinical Lecture. Mr. LEWIS. "Is Cervical Cancer Preventable?"
		1.00	Clinical Lecture to Dental Students in the Dental Theatre. Mr. A. R. F. THOMPSON. "Bridges".

HEROIN ADDICTION IN YOUNG PEOPLE

by
James H. Willis, M.B., M.R.C.P.Ed., D.P.M.
Consultant Psychiatrist, Stone House Hospital, Dartford, Kent

Introduction

The problem of opiate addiction in the United Kingdom has aroused concern in the past two years because of an apparent increase in incidence. The topic is one which arouses strong feeling quite apart from interest, and it can be fairly said that addiction has been given somewhat lurid treatment by certain mass media.

The reasons for this may lie in the value judgments of the writers concerned rather than in fact. Thus the addict may on the one hand be depicted as some sort of quasi-saintly mystic striving toward obscure forms of transcendental experience, or on the other hand as a degraded amoral criminal living in a delinquent sub-culture. However, neither of these extreme views fit the facts observed in those communities where the incidence and prevalence of addiction have been studied in systematic fashion.

Since the United States probably has the biggest narcotic problem in the Western World, it is worth looking briefly at some recent pertinent American findings. New York City has a population of approximately ten million, of whom around twenty thousand are opiate addicts. These are predominantly adolescents, the majority of whom started using drugs in their early teens (Winick, 1965). They tend to live in high density slum areas in conditions of extreme socio-economic squalor. They are more likely than not Negro or Puerto Rican, have poor school records, and live in overcrowded homes in which disrupted relationships abound against a background of barely controlled violence and tension. Their social prospects offer long periods of unemployment, or at best work of lowly skill.

The relationship of drug usage to delinquency in this population is not the simple one it appears. A heroin addict is likely to be an unreliable member of a delinquent gang, and the relevant data suggests that while drug use has no marked effect on delinquency per se, it does affect the type of delinquent act committed (e.g., stealing drugs, etc.) (Chein et al, 1964).

The typical New York addict is likely to have a major personality disorder and can be seen to use narcotic addiction as an escape from a deep sense of hopelessness related to his personal and social future. The "high", a feeling of ineffable pleasure following heroin injection, offers him initially effective relief, latterly a source of complete identification. In such a setting, it has been argued, addiction represents, for the deviant individual, an adaptive response to a hostile environment.

What is addiction?

Until recently it has been assumed that everyone who took opiates automatically became an addict, regardless of circumstance. American studies suggest, however, that it is not necessarily so, and that a valid distinction may be drawn between drug addicts and drug users.

A working model of addiction allies physiological dependence and craving to a state of total personal involvement with the drug. This latter aspect is often stressed in considering heroin addiction since it may cause extensive social disability by forcing the individual to neglect all other activities in favour of drug usage. This leads to a way of life in which the addict spends all his time in a search for further supplies of heroin thus preventing him from holding on to a steady job and disrupting his personal and social life to a catastrophic level.

Incidence

In the United Kingdom there are few helpful studies. The incidence of drug usage has tended to be low and until recently the majority of British addicts have been middle-aged and "therapeutic" addicts, i.e. people whose addiction followed the prescription of opiates for chronic painful conditions. Much has been written about the "British system" of prescribing heroin for addicts who need it but, in fact, up till now the number involved have been so low that the "British system" can hardly be said to have existed.

The Home Office keeps a record of the names of all patients receiving regular prescriptions of dangerous drugs. This provides a method of estimating the "official" incidence of addiction. In recent years these figures have shown a definite increase and are displayed in Tables 1 and 2.

Table 1.

	1958	1959	1960	1961	1962	1963	1964
TOTAL	442	454	437	470	532	635	753
Male	197	196	195	223	262	339	409
Female	245	258	242	247	270	296	344

If these figures are broken down by age the striking finding is the increase in the number of addicts under the age of 20 (Table 2).

Table 2.

AGES	1958	1959	1960	1961	1962	1963	1964
Under 20	—	—	1	2	3	17	40
20—34	—	50	62	94	132	184	257
35—49	—	92	91	95	107	128	138
Over 50	—	278	267	272	274	298	311
Unknown	—	34	16	2	16*	8	7

DRUGS	1958	1959	1960	1961	1962	1963	1964
Heroin (total)	62	68	94	132	175	237	342
Heroin & Cocaine	12	18	44	75	105	168	201
"NEW" CASES†	99	117	88	129	159	209	263

*This does not correspond with the published figure, which was 22, but has been adjusted in the light of subsequent information.

†This does not include recidivists.

Although these figures are, by American standards, small, there are good grounds for suspecting that the "underground" incidence of opiate addiction is much greater. Certainly the average English drug user seems convinced of this.

Sources

Heroin is easily obtained on the black market at a price of around ten shillings per half grain tablet. It is the most favoured of the "hard" drugs since it provides the most satisfactory effect—"buzz" (U.K.), "high" (U.S.A.).

The majority of users take it intravenously ("mainlining"), employing an eye-dropper rather than a syringe, having dissolved the tablet in a spoon heated over a match flame. The addict's kit is usually known as "the works"; indeed the field of addiction is pervaded by a jargon which gives to the drug using community a secret language and the trappings of a culture.

Aetiology

(a) Association with personality disorder.

Apart from "therapeutic" addicts, the aetiology of heroin addiction is far from clear. In theory it ought to be simple, i.e., Individual + Heroin = Addiction. In fact it is not. The reasons for starting drug usage given by addicts include such statements as "curiosity", "wanted a lift", "a friend gave it to me", etc., but these remarks do not help us to identify the susceptible individuals any more than do the lists of reasons given by alcoholics for their failure to control their alcoholic consumption.

Commonly, however, personality disorder and addiction coexist, as addiction offers relief to the deviant individual, often relief of an obscure kind that he finds impossible to describe, so that he has to fall back on statements such as "If you've never tried it, you'll never know".

(b) Social factors.

As mentioned before, American findings link addiction to complex situations of socio-economic deprivation. Other social pressures may include more sophisticated factors such as the need to be involved in an "in group" activity of a forbidden sort. Inadequate individuals may drift into drug usage in order to win the approval of the only people who will accept them, namely, other drug users, thus providing mutual support, albeit of a limited sort.

(c) Availability of the drug.

This is of paramount importance. In this country there exists the interesting situation in which the majority of illegally obtained heroin comes originally from legal sources. Some of it, presumably, is stolen, but very little. The rest is obtained on prescription and then re-sold by the addict. It is the apparent abuse of the availability of heroin which has led to current discontent and clamour for tighter control of prescription.

Manifestations of Heroin Addiction

(a) The Withdrawal Syndrome.

Quite apart from craving, the addict experiences a series of withdrawal symptoms when abstinence commences. These include restlessness and irritability, stomach cramps, nausea and vomiting, diarrhoea and rhinitis.

(b) Other signs.

Most addicts have injection scars and tattooing of the skin in the ante cubital fossae. The tattooing is caused by particles of soot from the heroin solution prepared in a spoon heated over a naked match flame.

(c) Pinpoint pupils: a well-known sign of opiate intoxication.

Treatment

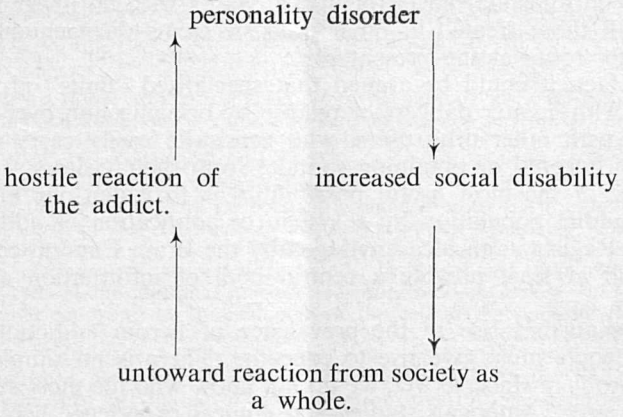
Treatment of the established addict is, on the whole highly unsuccessful, since such a large proportion of "treated" addicts return to drug usage. Withdrawal from the drug is the first step and needs must be gradual for the simple reason that an addict can rarely tolerate immediate cessation of the drug. The discomfort is such that he will discharge himself from hospital. For this reason it is customary to reduce the dose gradually over a period of two to three weeks. The time spent in this way can be usefully spent in building up the patient's poor physical state.

Thereafter what can be offered to the patient? There is little evidence that any form of psychotherapy is of value in ensuring abstention. The tendency is to try and apply social forces to the patient to help him find a new way of life. Ideally an addict should return to a community where he is less likely to encounter other drug users. This is rarely possible.

Some General Considerations

There is surprisingly little evidence that narcotic addiction is intrinsically destructive either physically or psychologically. It has been pointed out that many individuals start using drugs in their teens and "mature out" of the habit in their thirties. (Winick, 1962). This phenomenon is well documented in America but there are no similar studies in the United Kingdom. However, no doctor who has had prolonged contact with heroin addicts would condone its use since the habit tends to alter the individual's way of life in such a dramatic and disturbing fashion.

A major problem lies in the fact that the interplay of personality disorder and addictive process engenders a vicious circle situation which can be displayed thus:—


personality disorder
hostile reaction of the addict.
increased social disability
untoward reaction from society as a whole.

This means in practice that the true addict is a loser all the way unless he has a superabundance of determination and stability—features which the disordered personality never possesses.

Since, on the whole, the treatment of heroin addiction is so disappointing, it seems that the most satisfactory approach would be to concentrate on prevention. This can be tackled in various ways; the most obvious of these being to exert more control on the prescription of heroin to addicts. This has already been envisaged in the recommendations of the second interdepartmental committee. It is possible that this could lead to a further black market in heroin but it is difficult to see any alternative to some increase in control of prescription in the light of recent experience of over-prescribing.

Another, and more controversial suggestion is to acknowledge that deviant individuals may become addicts and accept the consequences. It could conceivably be that vulnerable individuals may be forced into addiction as the only escape from a social situation which is intolerable or overwhelming for them. Certainly the prevailing clinical impression of the youthful addict in this country is that of vulnerability and social inadequacy rather than delinquency.

All these comments, however, have no force for the doctor in the practical situation, who is faced with the decision of what to do with the addict who presents at his surgery and asks to be cured of his addiction. Clearly it is no use saying to such a patient: "You are the deviant victim of a combination of intra personal and environmental factors which have led to your present state." Such a patient may need admission to hospital rather urgently if he is asking to be taken off drugs. This in itself can be very trying for the doctor since there are not many hospitals prepared to admit addicts "off the street" as it were.

As yet, centres devoted to the care of the addict exist only on paper as recommendations, therefore the doctor uses those mental hospitals who are prepared to admit addicts.

It is said that in the busy admission ward of a mental hospital, the addict is likely to demand more in the way of care than the under-manned staff can give, but, in fact, since the bulk of heroin addicts who go into hospital go through such wards with no lower a relapse rate than those treated in other units, it seems disingenuous to use any other route at the present time.

In fact, it could be argued that specialised "units" provide the patient with greater dangers of relapse by bringing him over-much in contact with other drug users, who can quite easily carry on using drugs in hospital or obtaining supplies from their visitors.

One of the most useful possibilities is to widen our knowledge of the addict population by a system of notification of addicts to a Central Registry—an idea envisaged by the Brain Committee Report. This will at least provide a central pool of information about the problem.

The current rise in the prevalence of heroin addiction among young people must give rise to concern. There is no simple answer to the problem since, as yet, we do not know who the most vulnerable subjects are. American studies and clinical experience here, suggest that the young psychopath is most at risk, particularly when exposed to any degree of "stress". It has to be recognised, too, that such individuals may be made ripe for heroin usage by their encounters with an addict sub-culture, by example, invitation and suggestion. It is for this reason that the use of amphetamines and hemp by school-children can give rise only to disquiet. They may not harm the normal youngster, but they can only be dangerous to the young psychopath by contributing further to his social disability and his hostile relationship with the world as it is.

Finally a word on repressive and punitive measures, if only to dismiss them as being inhuman, uneconomical and a sure way of establishing a flourishing black market. Drug usage is a social and medical problem which can only be intensified if its "solution" is left in the hands of law enforcement agencies. It would be a tragedy if responsible opinion in this country were panicked into repressive legislation by present concern and the desire for an apparent quick remedy.

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Idem. 1965.

Acknowledgments

Tables 1 and 2 were prepared from figures kindly supplied to me by Mr. H. B. Spear, of the Home Office.

Dr. J. A. NISSIM

Guy's has lost a distinguished son in the recent death of Joseph Nissim, Reader in the Pharmacology Department.

He was born in Iraq in 1913 and began his studies at Guy's in 1938, qualifying M.B., B.S. in 1944. Early in his medical training his meticulous attention to detail and careful observation marked him out for a scientific career. His first paper soon after qualification described a new sign in dissecting aortic aneurysm*.

During his house appointments he began his famous work on iron therapy, which culminated in the introduction of a safe preparation of iron for intravenous administration. He was awarded a gold medal for his M.D. thesis on this subject in 1949. It consisted of over 1,000 pages in four volumes and gave some indication of his astonishing capacity for work.

During the past six years he pursued a detailed study of intestinal absorption and discovered that cetrimide in low concentration stimulated, and in high concentration inhibited the absorption of nutrients. This work lead to the Nissim hypothesis of intestinal absorption. Briefly he postulated that the proteins within the cells of the intestinal mucosa constitute mobile carriers which actively transport nutrient from the luminal pole of the cell to the opposite pole.

Although his work on absorption represents an important advance, he regarded his mathematical contributions of more significance. Later this month will be published his book, entitled "A New Physics of Matter and Energy". This magnum opus was the direct outcome of an urge to understand the various physical phenomena of nature in a simple way in which mathematical formulae remain associated with physical meaning throughout. The resulting work embodies the preliminary essentials of a number of theories which together form the rudiments of a new system of physics.

He was one of the best statisticians in the hospital, and those who turned to him for help found him kind and generous, though sometimes rapport was not facilitated by his difficulty in hearing.

His principles were of the very highest. He would never use a single sheet of medical school note-paper for any purpose unconnected with pharmacological work. Never at any time did he fail to exercise the utmost care and consideration in experimental investigations involving volunteers or himself.

To those of us who were privileged to know him well he was a great friend, and a man with an extraordinary insight into the whole gamut of human problems At home it was a happy event to entertain him. He was very fond of children and was deeply interested in their upbringing.

In his final illness a highly skilled nursing and medical team laboured relentlessly but in vain. To his relatives we extend our sympathy in the passing of a great Guy's scientist and a faithful friend. *Brit. Heart J. 8,203 (1946).

Mr. F. CURTIS

Mr. Frederick Curtis, formerly a general practitioner and surgeon at Redhill, died peacefully on the 11th February, 1966, in a Crowborough Nursing Home. He was 93.

He was born at Staines, the son of a surgeon, and indeed was the 7th successive generation of medical men in his family. He was brought up as a Quaker and educated at Bootham, York, and subsequently at Guy's Hospital, where he held the posts of Obstetric Registrar, House Surgeon, and Demonstrator of Anatomy. He qualified in 1901.

He interrupted his studies of medicine to pursue his other great interests of ornithology and botany and in 1897 joined an expedition to the Arctic in search of the breeding grounds of the Little Stint, and other rare birds. On his return he completed his medical training and obtained the F.R.C.S. Eng., having declined an invitation to accompany Captain Scott on his last expedition to the Antarctic.

In 1902 he married Edith Margaret Green and came to Redhill. For the next 43 years he built up for himself a reputation among colleagues, patients and friends alike as one of the finest examples of the truly devoted family doctor and surgeon. For this work, he was awarded the O.B.E. in 1919.

He was for many years senior surgeon, and later Chairman of the Staff of the East Surrey Hospital. He held on during the Second World War while two partners were away, only retiring at the end of it at the age of 72.

He enjoyed a long, full and most rewarding life, and leaves a widow, three daughters and a son.

CORRESPONDENCE

The Churn

SIR,—Great news, Guy's Hospital beat Charing Hospital in the semi-final, 18 points to 5 points.

We now look forward to still greater news on the 3rd of March.

Congratulations to the Guy's XV. We all wish you the best of good luck, a glorious victory and possession of the Cup once again.

This brings back to me vivid memories of The Milk Churn, which I presume will once again leave its hiding place, accompany the XV and supporters to Richmond Park, in all its glory.

I wonder how many Guy's men alive to-day remember or even know the history of the Milk Churn.

I have read the account in the Guy's Hospital Handbook for Medical Students.

May I, now 80 years of age, tell you my story as I remember it.

It was the season 1909, Guy's Hospital had won the Inter-Hospital Final and the Cup.

I shall never forget the cheering, the jubilation, the excitement continuing all the way back to Richmond Station.

At the station we boarded the next train to Waterloo. In my carriage I well remember Alex Seabrook, Reggie Curl and I think F. C. Hunot, with two others, their names I do not remember.

On the return journey the train stopped at Clapham Junction; our carriage pulled up opposite a collection of Milk Churns. Reggie Curl got out of the carriage picked up a Milk Churn and brought it into our carriage.

Continuing our journey, we now had to consider what we were to do with the Churn on reaching journey's end.

Some said leave it in the carriage; others said we will take it back with us to the College and with it adorn The Spit; this latter suggestion was agreed to.

Plans now had to be made for getting the Churn, and ourselves, through the Ticket Collectors' gate and out of the Station.

It was arranged that Alex Seabrook and I should each take a handle on the side of the Churn. We were to get well mixed up with the medical students and the general public off the train. This we did and got safely through the gates, having given up our tickets.

Seabrook and I now made for the Station Exit; once outside, we hailed a hansom-cub, we jumped in, put the Churn on the floor in front of us and drove off to the College.

On arrival at the College there was dear old Porter Gray standing in the archway, a very familiar sight. He gazed at the Churn and then at Seabrook and myself, and said, " Where did the Churn come from; if you have taken it from the Station, take it back to Waterloo now; if you do not you will get into serious trouble."

His words of wisdom went unheeded; we took the Churn down to the Spit and placed it upon one of the empty wall brackets accompanied by much cheering from all present.

I was living in the College at the time; later that evening Gray came to my room again begging us to return the Churn to the Station.

Needless to say, I for one had a very disturbed night with visions of the Police Court, severe fines or even worse, and the certainty of being sent down from the Hospital.

I had an early breakfast, after which I made my way to Waterloo Station to call on the Station Superintendent. On meeting him, I said, " I have called to tell you, we took a Milk Churn from Clapham Junction the previous evening." The Superintendent stopped me, saying " I know about the missing Churn taken by medical students. I am glad you have come to tell me the Churn is now at the College, Guy's Hospital."

He told me that the owner was a Surrey Farmer and that he was very angry. He was going to prosecute the culprits.

The Superintendent advised me to write to the Farmer. He then gave me the Farmer's address.

I wrote to the Farmer explaining the reason for our seemingly bad behaviour in taking away one of his Milk Churns.

We all very much regretted it; we begged for his forgiveness and meekly asked him if he would allow us to keep the Churn on payment for it. We should very much like to keep it as a Mascot.

I received a reply by return of post; it was a letter from a very angry man, full of threats and abuse; towards the end of his letter he had calmed down.

He now offered to let us keep the Milk Churn on payment of £6, and a promise that we would never be guilty of such behaviour again.

The £6 was very quickly made up between us and then sent post haste with a promise of good behaviour in the future.

Delighted at now being the lawful owners of the Milk Churn, we went down to the Spit and painted the Churn in Guy's Hospital colours.

I had the Farmer's letter in my possession for many years. It has, however, got mislaid or lost over the years.

I had the great pleasure of seeing the Milk Churn in its hiding place some six years ago.

I hope that the present and the future generations of Guy's men will always cherish the Milk Churn and look upon it as a treasured possession of Guy's Hospital Medical School.

H. V. LEIGH.

10th February, 1966.
Nottage House, Nottage,
Porthcawl, Glamorgan.

NOTICES

Miss Anna Freud

On the 10th March, 1966, Miss Anna Freud, Sigmund Freud's daughter, is coming to Guy's to give the second Sarah Stolz lecture in Child Psychiatry. Professor Peter Tizard will be Chairman for the meeting.

The Sarah Stolz lectures were endowed by an ex-Guy's man in memory of his mother, who was a refugee, and it is rather appropriate that Miss Freud, who herself came to England in 1938 as a refugee, should be giving the second lecture in this series.

A child of a genius with an international reputation, during his own lifetime faces special disadvantages. Few children become internationally known in their own right, but Miss Freud has achieved this. She was born in Vienna and was trained in Psychoanalysis by her father. For many years she was in charge of the Psychoanalytical Training Institute in Vienna. Since coming to England she has developed Psychoanalysis still further and has been specially interested in the problems of children with handicaps such as blindness and physical illness. It's not surprising that she has chosen to talk on "The Effects of Bodily Illness on the Child". She is a very gifted lecturer and we look forward to her visit.

Music Club A.G.M.

The Annual General Meeting of the Music Club will be held in the Physics Theatre of the Medical School on Thursday, March 10th, at 1 p.m. Everyone in the hospital interested in music, performer or listener, is urged to come. Future programmes and the formation of a music circle, to provide celebrity speakers and recitalists, will be discussed.

MICHAEL LINDOP,
Secretary.

Past and Present Boxing Club Reunion Dinner

Due to unforeseen circumstances, the date of the above dinner has been altered to Friday, April 1st.

As previously arranged, it will take place in the Miller of Mansfield, Snowsfield, meeting at 7.0 p.m. for 7.30 p.m. Those wishing to attend should contact me as soon as possible.

J. MANSIE, (President).

Guy's Hospital Students' Club
Annual General Meeting

Notice is hereby given that the Annual General Meeting of the Students' Club will be held in the Quiet Games Room in the Students' Club in the East wing of Guy's House on TUESDAY, 22nd MARCH, 1966, at 12.15 p.m.

A G E N D A .

1. To confirm and sign the Minutes of the last Annual General Meeting.
2. Matters arising from the Minutes.
3. To elect the following Officers for the year 1966-67:
   (a) a President of the Students' Club.
   (b) a Senior Secretary.
   (c) a Senior Treasurer.
   (d) a Student President from among the student representatives on the Council.
   (e) a Student Secretary from among the student representatives on the Council.
   (f) a Student Treasurer from among the student representatives on the Council.
4. To receive the Accounts of the Students' Club and of the Bar for the year 1964-65.
6. Any other business.

S. A. R. Cooke,
Hon. Secretary, Guy's Hospital Students' Club.

The Elderly Invalids' Fund

The Elderly Invalids' Fund every year gives information and advice to many hundreds of enquirers who have problems of various kinds which affect elderly people. In order to be able to answer enquiries about nurses more helpfully than is possible at present, the Fund wishes to explore the possibility of compiling a register of retired nurses who would like to help old people either by setting up house with them or by working for them in some other way. A small steering committee has been set up which includes representatives of the Central Council for District Nursing in London, the Queen's Institute of District Nursing, Royal College of Midwives and the Royal College of Nursing.

In no circumstances would a register be published. Only its existence would be made known and those who wanted information would be invited to apply to the Elderly Invalids' Fund.

The Fund warmly invites nurses who have retired or who will be retiring during the next twelve months and who are interested in this project to write in the first instance for a form. Letters need say no more than the writer might be interested. A form would be sent to her asking for details as to work required, area and so on. This carries no obligation. To ensure the maximum success it will be appreciated if the project is made known as widely as possible. Correspondence should be addressed to:

The Elderly Invalids' Fund, 34, King Street, London, E.C.2.
Tel.: Monarch 1877.

The Queen Alexandra Royal Army Nursing Corps Association (Brighton and Hove Branch)

The Chairman of this newly-formed Branch is Mrs. May G. Freeman, S.R.N. (née Dudgeon), who trained at Guy's from 1917—1920. Mrs. Freeman is anxious to be able to recruit additional members who have served in the Army, and who are also members of the Guy's Hospital Past and Present Nurses' League. Would anybody who is interested in obtaining further details, please write direct to Mrs. Freeman at 45, Park Gate, Somerhill Road, Hove 2, Sussex

A. M. Johnson,
Matron,
and Honorary Secretary of the Guy's Hospital Past and Present Nurses' League.

Theatre Club—Summer Production

The Theatre Club Committee would like anyone who is interested in producing a play in the summer to notify the secretary, mentioning the play or plays he or she would like to produce.

Guy's Hospital Ladies' Association

Your " JUMBLE " is our money. This is the time to Spring clean and by doing so help the Ladies' Association.

We are holding a Jumble Sale in the old Students' Club, Medical School, on Friday, 18th March, at 12 noon.

If you have any articles suitable for disposal on this occasion, would you kindly send them to The Secretary, Guy's Hospital Ladies' Association, Guy's Hospital, S.E.1, or leave them at 24, St. Thomas' Street, between 11 a.m. and 4 p.m. on Tuesdays and Thursdays, or the Superintendent's House on any other day of the week.

Mrs. Siddall will be very happy to receive China, Glass, Beads and Baubles and any "White Elephant" you are longing to get rid of, for the White Elephant Stall. Parcels should be left with the Porter for:—

Mrs. Siddall,
Librarian,
3rd Floor, New Guy's House,
London, S.E.1,

or she would be happy to collect if you telephone Fremantle 3890.

Mrs. Warner is holding a Prize Draw and would be very glad of offers to sell tickets, give a prize or money for a prize. Would anyone wishing to do so, please write to Mrs. Warner, 99, Harley Street, London, W.1 (Telephone Welbeck 0677).

Art Society

The Art Society's Spring Exhibition opens in the Garden Museum on Monday, 7th March.

SOUTHWARK AND THE ORIGIN OF DELFTWARE

by G. J. Dawson
of the Cuming Museum

Results of the Excavations at Potters Fields, 1965.

During the last years of the 16th century, religious wars broke out in the Low Countries, then under the tutelage of the Spanish crown. These events led to the destruction of the South Netherlands Maiolica pottery industry based on Antwerp, which remained under the control of Spain. The potters moved north into what has become Holland, and founded there the pottery industry which was later to be centred on Delft. From here or direct from the South Netherlands, potters also emigrated to England, then a haven for Protestant refugees.

In the first years of the 17th century, on the other side of the world, Dutchmen were also breaking the Portuguese monopoly of trade to the Far East by the capture of trading posts and Portuguese ships. Some of these ships were carrying loads of Chinese Ming Porcelain which is predominantly white with blue decoration and as a result these were off-loaded by the Dutch on the North-West European market.

This type of pottery became fashionable and in order to survive the Maiolica potters turned to imitating it, thus giving rise to a type of pottery known in England by the misleading title of Delftware.

From documentary evidence, scholars have discovered two schools of potters who are probably to be associated with the early development of English Delftware. One is associated with the name of Jacob Janson, who set up a workshop in Aldgate about 1570, the other workshop has been implied from a group of early 17th century Delftware and has been associated with the name Christian Wilhelm. It was known that Christian Wilhelm lived in St. Olave's Parish from 1617, and it had been suggested that his workshop was situated at Pickleherring Quay, a street which runs westwards along the river from the position of Tower Bridge. It was in hopes of finding a dumping of waste material from this kiln that the excavations were undertaken in January, 1965, at a site between Potters Fields and Vine Lane.

The excavation was carried out each week-end by the Southwark Archaeological Excavation Committee, under the direction of Dr. F. Celoria, with volunteer labour, between January and October, 1965. Altogether, 250 people helped and 3,000 square feet of the site was excavated to an average depth of six feet.

Before the site was cleared, a block of flats built in 1889 as "Improved Model Dwellings", stood there. The foundations of these, built on top of concrete footings were encountered down to the natural clay and made excavation difficult, besides destroying some of the evidence we were seeking. Beneath the floor level of these late 19th century flats appeared the remains of the red brick walls of the

The earliest feature on the site, red brick walls of a late 16th—early 17th century building, can be seen here at the bottom of the trench. The white rammed floor of this building can also be seen.

18th century warehouses associated with a granite cobbled road which was a continuation of Weavers Lane and was closed when the 19th century flats were erected. At the same time as the warehouses were erected, a boundary wall was built across the site. These structures were known to have existed from contemporary maps but right at the bottom was discovered a hitherto unknown building. This building was not associated with any datable objects, but it must be earlier than the mid-17th century and from the size of the bricks it could well be late 16th century. From the same layer, but not associated directly with the wall, were found two fragments of Hispano-Moresque tin enamelled ware imported from Spain and a very rare occurrence in England. This building had a rammed chalk floor and was associated with an area of cobbling. Above this building and below the 18th century warehouse we found what we had been looking for, a seven to eight inch layer of waste material from a kiln. This material was spread evenly over the whole of the excavated area and it became apparent that a rubbish heap of this material had been deliberately used to raise the level of this damp area along the banks of the Thames. Unfortunately, we do not know the precise date of this raising, but it must be earlier than the 18th century warehouses which lay on top of it and from the fact that the pottery does not seem to date later than the late 17th century, this period seems to be the most likely date for this spreading.

We then began to analyse the composition of this spread in order to discover what sort of pots were produced by this workshop and especially what sort of decorations they employed. Since, it is estimated, the excavations produced two tons of this pottery, this task is by no means complete, but a few provisional conclusions can be suggested. The pottery can be divided into two categories, coarse and fine wares. Coarse wares used for the common domestic processes were found but in small quantities. They are mainly green or yellow glazed plates and bowls. The remaining 80 per cent of the spread is comprised of fine wares. About 5 per cent were fragments of jugs and plates imported from Germany and France. All the rest can be associated with the Delftware workshop. These consisted of (1) **Kiln Furniture**—these are objects used inside the kiln or parts of the kiln itself. A number of highly fired bricks with many layers of glaze on them are probably part of the interior structure of a kiln. A large number of saggers, which are hollow, cylindrical, ceramic vessels used inside the kiln to prevent the glaze from being blackened by the smoke from the kiln fire, of all sizes were found. The saggers with big diameters are very short and probably used for large plates or chargers. The ones with smaller diameters are often taller and have vertical oval holes. It is probable that these were used for stacking smaller plates and saucers or hollow vessels such as drug jars. Elsewhere the holes in the wall of the tall saggers are small and triangular, into which are slotted triangular ceramic pegs, on which are placed the vessels. Since no oval pegs have been found, and the oval holes are in any case too large, it is difficult to know what function these holes performed. In place of these triangular pegs we found large quantities of trivets, flat, triangular ceramic supports which are placed inside the sagger between the vessels. There also occurred large numbers of little rolls and circles of clay, called bobs and setters, also used for separating vessels in the saggers. (2) **Biscuit.** Biscuit is the fired clay body of the vessel before the application of glaze. Because glaze and the pottery has a different melting temperature it is necessary with Delftware to fire twice, once for the body of the pot and once for the glaze. Many vessels were broken or thrown away for other reasons between these two firings and this is what is called Biscuit. There were a number of different types of vessel, the most common being plates or chargers and drug jars. Chargers are very large, shallow plates used for serving off rather than eating off. Drug jars are little jars for holding ointment and drugs, hence their name, but they were also used for holding other contents such as honey. Also found were a number of sack bottles for holding beer, mugs, saucers and " bleeding bowls " which are bowls with triangular horizontal handles pierced by one or three holes and get their name because it is thought that they were used by doctors when bleeding a patient. Besides these vessels we also found a number of Biscuit tiles.

(3) **Glazed Vessels.** A great number of fragments of glazed vessels were found, the shapes being the same as those for Biscuit. Nearly all of them were glazed white as is invariable with Delftware, and most had some form of decoration besides, except the sack bottles. The only vessels not glazed in white were the mugs, which were glazed

with a speckled manganese blue and purple glaze. Most of the decoration was in blue, although an occasional use of yellow and green also occurred. Besides geometric designs the most common decoration was "Bird-on-the-Rock" design. The chargers all have a translucent lead glaze on the back but the other vessels are glazed white on both sides. The tiles are also decorated with geometric designs and occasionally with a figure such as a leaping fox, running dog, camel, and jester. The tile decorated with the camel was particularly interesting since the glaze had been painted on but not fired. There were also fragments of figurines.

This material shows that the workshop in question produced only the fine Delftwares. None of the other pottery discovered in the excavation showed any signs of being kiln wasters and must be the domestic refuse from the workshop of the potter. Much of the Delftware had or did show these signs. The Biscuit is obviously a waste product since the final process had never been performed on it, as is also the camel tile where the glaze has never been fired. Besides this, many of the glazed wares showed signs of having been damaged in the kiln either by the trivets, bobs and setters sticking to the vessel, by two vessels sticking together, by the glaze running, or by a vessel actually breaking up or being distorted during the firing. The material also showed that the workshop in question produced vessels decorated with the "Bird-on-the-Rock" design which had been associated with Christian Wilhelm and which are imitations of Chinese Ming Porcelain, which has a similar decoration. The Delftware with this decoration had been dated between 1620 and 1650. However, further documentary research has shown that Christian Wilhelm lived not at this end of Tooley Street as one scholar had thought, nor in the Maze, a street turning south off Tooley Street, as another had thought, but somewhere between Tooley Street and the river near London Bridge. This raises a number of problems for the interpretation of the site. It is possible that Christian Wilhelm lived away from his workshop but there is a certain amount of evidence against this. In a Petition drawn up by him to the King, his drying shed is mentioned as being in his garden and in the Surrey and Kent Commission of Sewers there is a reference to an instruction to a certain Thomas Townsend, in 1638, to clear the sewer round his pot house, and while Christian Wilhelm was still active in that same year it seems likely that Thomas Townsend was the owner of the kiln near Pickleherring Quay. Thus it would seem that there were two workshops, one at Pickleherring Quay producing "Bird-on-the-Rock" designed pottery and another, Christian Wilhelm's, producing some other form of Delftware. But we know that from 1628 to 1638 and perhaps later, Wilhelm held a monopoly from the King for the production of Delftware and, while these monopolies were not always effective in the early 17th century, it seems unlikely that a person could get away with an infringement of it while living only at the other end of the road from Wilhelm. This problem has no easy solution and must await the results of further work.

Another important result of the excavation has been to show that Delft tiles, hitherto thought to be produced in the South Netherlands, particularly Antwerp, were also produced in England at this period.

REVIEWS

ORAL MEDICINE.

Diagnosis and Treatment by Lester W. Burket. 5th Edition. 620 pages. *Pitman Medical.* £5 5*s.* 0*d.*

Burket's " Oral Medicine " is now in its 5th Edition and must therefore be regarded as a book successful in a certain field. It would perhaps be useful to the keen practitioner or to the person studying for a higher examination in dentistry, who wished to be reminded of many conditions, but who did not wish detailed and exhaustive discussion of any particular topic. There is the usual preliminary padding on such matters as " Medicodental Relations" and history taking, including an 80 item questionnaire ending with " Do you feel that you mix well with people?" No suggestion is, however, made as to how the possible answers are to be evaluated. When it comes to the haemorrhagic diseases on the other hand, where a detailed history is of the greatest importance, the reader is left in the lurch. Nevertheless the book now runs to over 600 pages so that before getting half-way through it, one begins to wonder how the rest of these pages will be filled. There are in fact 39 chapters, and some stretching of the subject has been necessary to find something to fill them. Broadly speaking, the book consists of sections on oral disease proper and on general disease which may show oral features. This is useful in a way, but for the arbitrary, even eccentric fashion in which diseases have been classified. Thus " histiocytosis " is called a bone disease, whereas Schüller Christian disease, generally nowadays considered a non-lipoid histiocytosis, seems to be regarded as something quite different, and is dealt with separately several chapters later as a disease of lipoid metabolism. Similiarly among the blood disorders, one finds no mention of pernicious anaemia which, with the Plummer Vinson syndrome, turns up much later among the Diseases of Metabolism. In addition, in spite of the number of revisions, some of the illustrations remain appallingly poor in quality. On the whole then it would be fair to say that this is a useful book with many helpful references, but in view of the size and price, not quite as authoritative as one should reasonably expect.

R. A. LAWSON.

REVIEW OF PHYSIOLOGICAL CHEMISTRY

(10th edn.). Harper-Blackwell. Pp. 467. *Price* 50*s.*

There are many useful features about this book, especially its physiological approach and the provision of numerous diagrams, formulae and lists of normal concentrations in blood and other body fluids. The sections on enzymes and blood proteins are particularly good. The book may thus be recommended as a work of reference to those who have learnt or are unconcerned with fundamental biochemical concepts. However, the physical chemical basis is unsound throughout; most of the illustrations appear to be drawn by someone who understands the ionic theory, but the text does not altogether support this view. Apart from the assumption that non-ionised organic phosphonic acids alone take part in biochemical reactions, there are examples of pieces of old-fashioned physical chemistry such as one might expect to find in out-of-date textbooks of physiology, but which have long since disappeared from the modern literature. This is the more surprising, since this is the 10th edition of a well-known work. Although the book is reasonably priced, the student will do well to be very careful if he takes it as a standard biochemical textbook. Others may be glad to have it at hand to look up formulae, metabolic pathways and normal values.

G.A.D.H.

RADIOLOGY OF THE TEETH AND JAWS.

Frank L. Ingram, 1965. Arnold London. Pp. 256. *Price* 55*s*.

When it became known that Dr. Frank Ingram was preparing a second edition of his book, the first edition of which appeared in 1950, its publication was awaited with the greatest of interest.

As in the previous edition, the book is in two parts. Part I deals with the physical principles of radiology, processing and the radiological techniques special to the jaws and teeth. Part II comprises a systematic coverage of the radiological aspects of abnormalities and diseases of the hard and soft tissues of the face and jaws.

In this edition many illustrations have been replaced and there is a large number of additions. These have been selected with the greatest care and the author has not made the common fault by radiologists of including an illustration simply because it belongs to his collection. With only rare exceptions, the radiographic illustrations are of the highest order, setting standards of quality and definition which authors and publishers of books and articles may well strive to emulate. The text is easily readable, follows a logical sequence and benefits greatly from the sensible and generous use of sub-headings to sections of chapters.

Since the first edition, knowledge has advanced in the fields of radiation hazards and radiation damage, and up-to-date information on both these subjects is included in the new edition. Another aspect of radiology which has developed since 1950 is the use of contrast media to demonstrate the sinuses, joint spaces and glandular architecture, and in the dental field there has been further development in the technique of sialography. In this edition, Dr. Ingram describes the principles of sialography and the interpretation of the radiographic projections, with precise details of his own technique.

The first edition of this book appeared soon after the second world war at a time when there were few new dental books on the stalls and when the whole of dental education was in an expansive mood. It was indeed a publishers' market. The climate for the appearance of a second edition, however, is quite different. The bookstalls are loaded and the student has the choice of half-a-dozen or so books on dental radiology. Nevertheless, "Radiology of the Teeth and Jaws" will be the choice of many undergraduate and postgraduate students and practitioners, for it covers the subject fully and adequately and is up-to-date; it is attractively presented, easily readable, the subject has not been blown up out of proportion, and at 55s. it compares most favourably with its competitors.

M. N. NAYLOR.

CASE STUDIES IN ANATOMY.

E. Lachman, Oxford University Press, New York, 1965. Pp. 238. *Price* 24*s*.

This book was designed primarily for preclinical students as an illustration of the application of anatomy in clinical medicine. It consists of thirty topics in which a clinical condition is discussed in terms of the symptoms and signs, prognosis, treatment and relevant anatomy. Despite the claim that all major areas studied in the gross anatomy course are covered, there are many omissions which prevent the reviewer from recommending this work to final year students revising surgical anatomy.

Each topic is dealt with in an interesting and discursive manner, but only five are really worth reading, the remaining twenty-five being of interest, but not great value. Literature-conscious readers would find the irregularities of syntax irritating.

One cannot advise the purchase of this book with such a limited role when more complete alternatives are floating in the ocean of textbooks.

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SPORT

As this edition of the Gazette is distributed, the Cup will have been won and lost. We cannot, however, go to press without mention of the Final, so we offer Gazette Pathé News for retrospective interest. Our limited powers of prophecy, unfortunately, allow no more than our saying that the winning will no doubt be carried out by Guy's, and the losing by our old rivals, who were forced to leave St. Thomas's Street some years ago when S.E.1 became too small for both our hospitals.

The game, in fact, promises to be very hard and probably very close. Our possible slight superiority in the three-quarters and especially wings, will probably be neutralised by quick, devastating tackling from a defence-conscious opposing line so that the result will depend largely on forward dominance and the use made of chances from loose balls. There is also, of course, the scourge of the penalty which may itself decide the issue. Once the Guy's pack succeeds in producing a quick ball from the loose, then Guy's three-quarters will be well capable of scoring tries. Let us hope that such chances are not squandered by bad kicking.

We are told that St. Thomas's open-side wing forward has very recently been relieved of his appendix, and that this was performed through the smallest of incisions in the hope he will be fully recovered for the day. Our sympathy goes to St. Thomas's—may his incisional hernia be repaired in the minimum of time and under the minimum of anaesthesia, so that he will also be available for any replay that may be required. Illness has also visited the Guy's XV, though, mercifully to a lesser degree. At the time of writing, the skipper, J. E. Davies, lies in Wilkes with "'flu", while one or two others are still recovering from the epidemic. Come Thursday, however, the whole team is expected to be fully fit.

The A XV at present are preparing themselves for the responsible task of looking after The Churn on Cup Final day. This will be appearing for the first time in five years and so any Guy's man presenting himself to the guard of honour in order to view his mascot, is requested to identify himself clearly as friend or foe. The A XV have their own Cup Final worries, too, for they duly defeated Middlesex 32—3 in the Junior Cup semi-final. A breakdown in the bush telegraph resulted in them borrowing D. A. Edgar from the Boxing Club to complete the team. He now claims his right to defend The Churn, when his more natural talents should prove of considerable value. The side will meet either Bart's or Mary's in the final which, it is hoped, will take place on Tuesday, March 8th.

The Boxing Club has been showing considerable activity of late, sharing meetings with Oxford and Cambridge Universities and the Lynn. In the two former encounters Guy's fought exceedingly well and boosted the Club's reputation accordingly. Against the Lynn, our more experienced boxers could not be matched and the only four to box lost somewhat unflatteringly, though Chater provided the gathering with some delightful, almost traditional, light-hearted entertainment. The Club has now reached a crucial stage in its history, for many of the more experienced members are leaving Guy's. Gibson especially will be sorely missed, and Edgar's and Crawford's departures will leave the ranks seriously depleted. The Club still possesses considerable experience and skill in Onyeama and Stansfield, who with three or four other stalwarts will provide a very adequate nucleus for the immediate future. New members, however, are urgently required, whether experienced or novice, if the Club is to continue to prosper. W. Onyeama (Captain) and B. Hartley (Hon. Sec.) will be pleased to hear from any interested parties.

Two victories are reported without great enthusiasm by the Hockey Club during the past fortnight against Queen's Cambridge, and Sevenoaks. The second team defeated Bart's in the semi-final of the Junior Cup and so advance to the final for the fourth consecutive year, when they meet St. Thomas's.

Apologies are offered to the Hockey Club and any other interested readers, for the ridiculous "good equality" for "goal equality" which slipped through the proof reading in the last issue. Observant readers may have noticed also that where "or St. Mary's" was successfully deleted at the proofing stage from the rugby news on hearing the result of the other semi-final, Guy's were left playing "either St. Thomas's". I feel suitably penitent.

DIARY

Mar. 5.—Rugby v. Old Alleynians. Away.
Hockey v. Tonbridge. Away.
Cross-Country (U.H.) v. Edinburgh Univ. At Edinburgh.
,, 12.—Rugby v. Nuneaton. Away.
Hockey v. U.S. Portsmouth. Away.
Cross-Country (U.H.) v. Lloyd's Bank. At Barnet.
,, 16.—Cross-Country v. Imperial College. At Parliament Hill Fields.

REPORTS & RESULTS

RUGBY

GUY'S v. LONDON IRISH

At Sunbury-on-Thames
Saturday, February 19th, 1966
Result: won 8—6

On this sunny afternoon Guy's became yet another London club to beat London Irish this season. We must not, however, underestimate Guy's performance, but it was felt that their score could have been more convincing.

Guy's kicked off into the sun and against a slight breeze and immediately pressed into the London Irish half.

However, their command seemed thwarted when Guy's back row were penalised for breaking from the scrum after five minutes of play, and J. Haynes gave London Irish the first score with a fine 35 yard kick.

Guy's attack continued, and the pack, gaining three against the loose head in the first half, were providing the threequarters with good possession. Kingdon and Peace jumped well, with good support from the rest of the scrum, to dominate the line-outs.

Guy's came close to scoring when I. Morgan was tackled 15 yards from the line after a fine interception by Beacham.

Pressure mounted, and Guy's attempted three push-over tries, only to be held at bay. Guy's then gained the ball from a scrum and gave it along the line. Passing from Rowlands, Beacham and Horsley put Morgan away, who, after handing off three men, scored a fine try in the corner, which was not converted. Guy's continued to have good possession, and despite a good service from Swift, connecting well with Rowlands, it came to no positive conclusion between the centres.

Credit must be given to M. Byrne who, with his long touch kicking, was able to gain useful ground back into Guy's half for London Irish.

At times the London Irish seemed as if they might score, but good covering by Sharp, Cockburn and Thorburn prevented this, especially from the few "Gary Owen's" produced from London Irish.

Guy's continued to mount pressure in the second half, and it can only be said that it is unfortunate that they spoilt their own very fine efforts with poor handling at the crucial moment.

However, Thorburn, gathering the ball from a knock-on by the Irish fly-half, passed to Rowlands who, after drawing his man well, was able to give Ross the ball for a good try after a 30 yard run. This was successfully converted by Elliott.

Hey gained a further five against the head, and possession was good. Both Stansfield and Davies showed their unique fitness by covering so much ground.

Guy's were unlucky not to score again when Beacham again intercepted and underestimated his own ability by attempting to pass instead of scoring himself.

Just before "no sides", Brolly dropped a goal for London Irish from 15 yards following a forward rush by London Irish.

To the Irish we can say "Well done, Willy Doyle!" For Guy's we can say they played an entertaining, open game, but one would wish that their handling could be better at the vital movement, then they would have their own worthy rewards in the Final for the Cup.

Team: D. R. Elliott; J. R. M. Ross, S. Horsley, R. Beacham, I. J. Morgan; B. J. Rowlands, P. G. F. Swift; J. E. Davies (Capt.), G. B. Hey, R. Stansfield, P. K. Peace, A. J. Kingdon, M. C. Sharp, J. M. Cockburn, C. W. Thorburn.

J. G. PAYNE

Junior Cup Semi-final

GUY's v. MIDDLESEX

At Chislehurst, Wednesday January 16th, 1966
Result: won 32—3

On Wednesday, February 16th, 14 regular players and Guy's lone supporter took the field against Middlesex Hospital. Guy's, from the kick off, immediately took the initiative and were soon three points up. The forwards from set scrums were consistently heeling the ball back quickly, which the threequarters made ample use of with swift direct running. By half-time the score was 17—3 to Guy's. Middlesex' lone score being a penalty kick in one of their rare sorties into Guy's half.

The threequarters exertions in the first half appeared to leave them a little unwell at half-time, and without Osborne, who had to leave the pitch with a recurrent knee injury early in the second half, it was some time before Guy's scored again, though they were never outside the Middlesex half. Middlesex lost heart, and Guy's forwards started running and interpassing the ball and many times were about to score when a pass was intercepted by a retreating Middlesex forward. Late in the match Guy's crossed three more times, each try being converted by A. Morris.

Guy's opponents in the final will be either Bart's or Mary's, and the "A" XV must enter the game with a very good chance of pulling off their half of "the double".

Team: A. Morris; D. Edgar, D. Lewis, D. Osborne, G. Thomas; S. Horsley, B. Moore; E. Neville, C. Lewis, A. Forbes, C. Neville, K. Brown, D. Curzon, D. Hendrick (Capt.), C. Doyle.

D. A. EDGAR

HOCKEY

GUY'S v. SEVENOAKS

At H.O.P. Saturday, February 26th, 1966
Result: won 3—1

Guy's were one of the few clubs fortunate to play after the heavy rain of the preceding week, and, in spite of the adverse conditions, which included a heavy shower in the first half, still managed to play constructive hockey. A hat-trick by Appleby, who was well supplied by the wings, Pearson and Cripps, gave the team its first win this season by a margin of more than one goal.

Having gained a 2—0 lead, Guy's seemed to ease off, and Sevenoaks scored following a short corner, the first shot from which was well saved by Rear—alas though, nobody was able to clear the ball and the opposing forwards did well to follow up and put the ball in the net. For the most part, though, the defence looked solid. Mention should perhaps be made of full-back Vellacot, a fresher who started the season with the 3rd XI, but who now looks quite at home in the 1st XI, and who played yet another very sound game.

Incited by the stirring words of the Captain Brooks, and following his hard-working example, the team went into attack again and made sure of the game by scoring a third goal.

A very satisfactory performance—the only regret being that the result was not in the Sunday papers—a lapse by ? who forgot to 'phone it through!

J. K. CRAFTS

Junior Cup Semi-final

GUY'S v. BART'S

At Chislehurst. Wednesday, February 23rd, 1966
Result: won 3—1

Guy's started this match at Chislehurst very slowly and there were a number of anxious moments in the first ten minutes with the defence being hard pressed. This initial period culminated in a short corner to Bart's, from which they scored. This lead was short-lived, however, as Guy's then began to play as a team, and soon Dodd was on hand to score from a hard cross from the right. Guy's continued to attack for the remainder of the first half and had many near misses.

At the start of the second half Guy's kept the upper hand and were soon awarded a short corner. Turfitt gathered the push-out, beat two defenders with excellent stickwork, and gave the goal-keeper no chance. Soon afterwards a cross from Rushmer found Jones unmarked on the "25" and he scored a good goal.

The last fifteen minutes brought rain, and found Guy's very much on the defensive again. Only sterling work by Salomon and some good saves by White prevented Bart's scoring. The defence were happy to hear the final whistle.

With this win Guy's enter the final for the fourth year in succession, and with two outright wins and one shared victory behind them, they will at least have a psychological advantage over St. Thomas's in the final.

Team: N. White; J. Salomon, R. Jenkins; S. Worthington (Capt.), N. Turfitt, P. Rushmer; A. Godfrey, M. Jones, A. Brooks, N. Dodd, M. Tan.

S. WORTHINGTON

BOXING

Since February 1st, when the Club lost narrowly, Guy's have competed in three matches, all within 10 days of each other, and our fortunes have fluctuated sharply from match to match.

On February 1st, Guy's sent a team to box Oxford University at Oxford Town Hall. Though the match was lost three bouts to one, Oxford were unable to match W. Onyeama, R. Stansfield and T. Gibson, all of whom had won against Cambridge University ten day's previously, and in addition, the club secretary's opponent from Oxford cried off at the last minute with 'flu, and so B. Hartley was also unable to get a match.

In the first bout of the match A. Craig, of Guy's, was matched against a very capable Oxford University opponent in S. C. Forrest. Craig fought well at close quarters in the opening minute of each round, but inevitably ran out of steam in the latter half of each round, when the superior fitness of the Oxford man came to the fore. A bad third round for Craig, when he shipped a fair amount of leather, sealed the bout for Oxford.

D. King, at lightweight, having only his third contest for Guy's, came up against a very capable campaigner in P. Thick, boxing in his second season for Oxford. A more varied selection of punches and a persistent attack, enabled Thick to gain a points victory over the Guy's man, who put up a spirited performance in losing.

Everything now hinged on D. Edgar of Guy's, our "old campaigner" who, with more than a score of fights behind him, proceeded to make things very unpleasant for a bewildered N. Dewar, of Oxford, from the very opening bell. A rain of blows from Edgar, some of which landed in questionable territory, had Dewar scuttling for cover for most of the three rounds. Most of the time Edgar was on the attack with his retreating opponent stopping only long enough to plant the occasional left counter on Edgar's features. It looked as if Edgar had the fight wrapped up when in the third round he dropped his opponent for two counts. However, for some inexplicable reason the judges awarded the decision to the Oxford man, who looked even more baffled than the Guy's supporters did.

With the match now lost, J. Crawford, of Guy's, at light-middleweight, boxed the last contest against S. W. Watson, of Oxford. After a hesitant start, in which the Guy's man did little more than direct a basilisk glare in the direction of his opponent, Crawford really got down to business in the second round and punished his man severely with ramrod left leads followed by powerful right crosses. At the end of the second round the Oxford man looked much the worse for wear and with blood streaming from his nose and mouth, was retired by his corner.

It was unfortunate that Guy's lost the contest as every boxer had put up a very spirited display. It is hoped that next year when Guy's will be hosts to an Oxford visiting team, the result will be different.

W. ONYEAMA

GUY'S v. LYNN B.C.

At Manor Place Baths
Tuesday, February 22nd, 1966

Result: lost 4—0

Guy's boxing reached its lowest ebb in the annual Guy's v. Lynn B.C. match for the Matt Wells Trophy, on Tuesday, February 22nd. This match was the main feature in a show in which many outstanding boxers from several London clubs appeared.

Support for Guy's boxers in this show has always been enormous, and this is in fact the only show of the year in which the Lynn B.C. do not lose money. It was therefore, all the more regrettable that in not one of the four match contests did any of the Guy's boxers offer anything more than token resistance or aggression to their opponents.

When an audience can only laugh at our efforts in the ring, the time has surely arrived when we should begin to feel that all is not well with boxing at Guy's.

The match, incidentally, was lost by four bouts to nil.

A. L. STANHOPE

On Wednesday, February 23rd, the Guy's boxing captain, W. Onyeama, boxed for a University team in their match against the Belsize boxing club. W. Onyeama was matched with the Belsize Club captain, R. Stubbings, who in his spare time plays rugby for the Wasps. This was the second time that these two had met. On the first occasion, last November, Onyeama had narrowly outpointed the Belsize man. At London University the Guy's man made it "two-love" in the series, when he again won a hairline decision over Stubbings.

Rocking left jabs gave Onyeama a comfortable lead at the end of the first round, but by the third round it looked as if the non-stop aggression of the Belsize captain might win him the fight. However, in the third round Onyeama caught his man flush on the chin with a hard right hook, which stopped Stubbings in his tracks, and allowed the Guy's captain to keep the fight at long range where his long left lead won him the points.

B. HARTLEY

CROSS-COUNTRY

With the fixture list drawing to a close, the drive that the Club had at the beginning of the season is waining. On 12th February, at the U.H. championships, the team sustained its worst defeat for a long time by coming 4th, behind Bart's, the London, and Mary's. The race was over the U.H. home course at Chingford in very muddy and heavy-going conditions. Steighty, of Mary's—a former U.S. national track champion—was the individual winner, and Bart's, for the 4th year running, took the team title. With the exception of the Secretary, the depleted Guy's team gave of its best, and Bowen-Jones did well to be the first Guy's scorer home. 57 runners finished the course.

13, Witting (non-scoring); 17, Bowen-Jones; 20, Smith; 22, Waterhouse; 26, Wilson; 33, Avery; 34, Huddy (non-scoring); 42, Choat; 48, Lee; 54, Ibbotson.

The following Wednesday, February 16th, there being no one else available, Bowen-Jones and Smith ran in the South West Essex Technical College invitation 4½-mile road race. Smith finished 25th out of a large field.

Three day's later, on February 19th, Bowen-Jones, Avery, Halestrap, Choat, Vernon, and Wilson, went to run in the Hyde-Park 6 x 3 mile road relay. This has become a top event in the National calendar, and it attracts some very good entries. Of the 95 teams completing, Leeds University was favoured to win. Each lap was three miles round the Serpentine, and by the beginning of the 6th and final stage, the leading team had gained more than 15 minutes on the slowest team. A fierce challenge was put to Leeds and Edinburgh Universities by Borough Road Training College, but Fergus Murray, fresh from his win in the British Universities Championships, showed his strength by leading Edinburgh home to win the team title. Unfortunately, the complete results have not yet been circulated.

On Wednesday, 23rd February, only three runners were fit enough for the final match of the London Colleges Cross-Country League. The course was easy-going over 5½-miles in Richmond Park. Gordon Pirie led the 90 competitors for two miles up to the first marker.

51, Bowen-Jones; 54, Waterhouse; 57, Wilson.

The last match of the season, other than the U.H. fixtures, will be on 16th March, against Imperial College and Latymer Upper School, on the University course at Parliament Hill Fields.

R. M. WILSON

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy for the appointment of **Senior Registrar in Ear, Nose and Throat Surgery to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.**

The appointment will be from 3rd July, 1966, to 30th September, 1967. The appointment will be made jointly by the bodies concerned and will be held until 30th September, 1966, at Lewisham Hospital, and for the remainder of the appointment at Guy's Hospital. The post is subject to the Terms and Conditions of Service of Hospital, Medical and Dental Staff (England and Wales). Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **19th March, 1966.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy for the appointment of **Senior Registrar in Psychological Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.**

The appointment will be for four years from 1st May, 1966, with duties until 30th November, 1967, with the Bexley Group, and for the remainder of the appointment at Guy's and St. Olave's Hospitals. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales). Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **19th March, 1966.**

Part-time female assistant required for binding slides, etc., in Photographic Department. Approximate number of hours per week—12. Apply in writing to the Secretary, Guy's Hospital Medical School, London, S.E.1.

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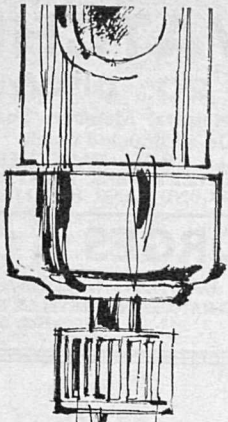

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HOUSE APPOINTMENTS

GUY'S HOSPITAL, S.E.1.

March 1st, 1966

Assistant House Surgeons
To:
Mr. Lawrie — Mr. B. S. Ricketts
3 *months*
Mr. Glover — Mr. M. S. Vernon
3 *months*
Mr. Brain — Mr. P. C. Pietroni
Appointed for 6 *months, the first* 3 *as A.H.S.*
Mr. Beard — Mr. D. J. Hendrick
Appointed for 6 *months, the first* 3 *as A.H.S.*

Assistant House Physicians
To:
Dr. Mann, Dr. Scott and Dr. Bishop — Mr. M. H. Jourdan
Appointed for 6 *months, the first* 3 *as A.H.P.*
Dr. Hardwick, Professor Trounce and Dr. Deuchar — Mr. D. B. Mathias
Appointed for 6 *months, the first* 3 *as A.H.P.*
Dr. Baker, Dr. Houston and Dr. Grimble — Mr. T. H. Guerrier
Appointed for 6 *months, the first* 3 *as A.H.P.*
Dr. Kauntze and Dr. Joiner — Mr. P. K. Peace
Appointed for 6 *months, the first* 3 *as A.H.P.*
Professor Butterfield and Dr. MacLean — Mr. G. Smith
Appointed for 6 *months, the first* 3 *as A.H.P.*

Casualty Officers
Mr. D. G. Gourley
Mr. C. E. M. Lamb
Mr. W. T. Lamb
Mr. T. N. D. Peet
Mr. J. D. Rogers
Mr. P. A. D. Williams
} 3 *months*

House Surgeon to the Surgical Unit
Miss C. J. S. Lawrie
3 *months*

House Surgeons
To:
Mr. Eckhoff — Mr. C. G. C. Gaches
3 *months*
Professor Atkins — Mr. N. W. D. Walshaw
6 *months*
Mr. Wass — Mr. P. D. Davies
3 *months*
Mr. Blackburn — Mr. A. M. Morris
6 *months*

House Physicians
Dr. Mann, Dr. Scott and Dr. Bishop — Mr. B. H. Hicks
3 *months*
Dr. Hardwick, Professor Trounce and Dr. Deuchar — Miss J. P. Pearce
3 *months*
Dr. Baker, Dr. Houston and Dr. Grimble — Mr. D. R. Bevan
6 *months*
Dr. Kauntze and Dr. Joiner — Mr. G. A. Pettitt
6 *months*
Professor Butterfield and Dr. MacLean — Mr. M. B. Barnett
3 *months*

Resident Obstetricians
Mr. V. E. Egwuatu — 3 *months*
Mr. A. I. Ogunleye — 6 *months*

Gynaecological House Surgeon
Mrs. T. D. Pietroni — 6 *months*

Throat and Ear House Surgeons
Miss J. R. Townsend — 3 *months*
Mr. D. P. Leiberman — 6 *months*

Neurological House Physician
Mr. A. L. W. F. Eddleston — 6 *months*

Orthopaedic House Surgeons
Mr. A. M. Roberts — 3 *months*
Mr. J. S. Gregson — 3 *months*

Dermatological House Physician
Miss A. Stokes — 1.2.66—31.8.66

Genito-Urinary House Surgeon
Mr. P. J. C. Baxter — 3 *months*

House Surgeons to the Thoracic Unit
Mr. T. C. Davies — 3 *months*
Mr. P. C. Smith (S.H.O.) — 6 *months*

Children's House Physicians
Miss J. A. Chown — 3 *months*
Mr. A. R. M. Upton — 6 *months*

House Physicians in Clinical Pathology
Mr. A. J. Knell — 3 *months*
Readvertised — 6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Mr. M. Elliott — 6 *months*

House Physician in Child Psychiatry
Mr. M. Kamien — 3 *months*

House Physicians in the Department of Psychological Medicine
Mr. P. Nott — 1.4.66—30.9.66
Mr. K. F. Standage — 1.4.66—30.9.66

R.M.O.s in Nuffield House
Mr. J. F. Steele-Perkins — 1.1.66—30.6.66
Mr. A. Thomas — 1.3.66—31.8.66

Resident Anaesthetists
Mr. D. G. Nancekievill (S.H.O.) — 3 *months*
Mr. B. R. T. Smith — 3 *months*
Mr. R. K. R. Innes (S.H.O.) — 6 *months*
Mr. T. E. J. Healy (S.H.O.) — 6 *months*

Children's House Physicians at the Evelina Hospital
Miss N. Yasmin — 1.12.65—31.5.66
Mr. B. G. R. Neville — 1. 2.66—31.7.66
Mr. J. H. T. Marshall — 1. 4.66—30.9.66

Casualty Officer at the Evelina Hospital
Dr. M. Suleman — 1.2.66—31.7.66

St. OLAVE'S HOSPITAL

House Physicians to Dr. Mason and Dr. Cox
Mr. A. W. J. Medhurst — 1.1.66—30.6.66
Mr. I. A. Sutherland — 1.1.66—30.6.66

House Surgeon to Mr. O'Flynn
Mr. A. H. Mowbray — 1.1.66—30.6.66

House Surgeon to Mr. Lewys-Lloyd
Mr. J. A. E. Knowles (S.H.O.)

Gynaecological House Surgeon
Mr. S. M. Wood (S.H.O.)

Casualty Officer
Mr. B. N. Jayaswal (S.H.O.)

NEW CROSS HOSPITAL

House Physicians in Medicine and Geriatrics
Mr. A. D. Milner (S.H.O.)
Mr. J. Wallace — 3 *months*
Mr. D. J. Simler (S.H.O.)
Mr. C. R. Sheard — 6 *months*

Orthopaedic House Surgeons
Mr. D. T. Goradia (S.H.O.)
Locum pre-registration house surgeon until 31.5.66

S.H.O. to the Rehabilitation Unit
Advertised

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases:
Mr. T. Roe

JOYCE GREEN HOSPITAL

House Physician: Readvertised

LEWISHAM HOSPITAL

House Surgeon to Mr. Cavendish:
Mr. J. R. Hockey
House Surgeon to Mr. Le Brun:
Mr. G. Llewellin
House Physician to Dr. Llewellyn Smith:
Mr. T. L. S. Williams

ORPINGTON HOSPITAL

House Surgeon with Physical Medicine:
Readvertised

QUEEN MARY'S HOSPITAL, SIDCUP

House Physician: Mr. D. R. J. Quickenden
House Surgeon: Mr. S. E. Letanka

R. J. CANN,
Acting Superintendent.

February 18th, 1966

PASS LIST

Correction to Pass List published in Gazette of February 19th.

P. J. Rushmer has completed his examination.

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CHANGES OF ADDRESS

Dr. and Mrs. Dennis C. Humphrey, to 19, Princes Court, Park Lane, Wembley, Middlesex.

C. R. K. Smith, to Weem Cottage, Weem, Aberfeldy. Telephone No. Aberfeldy 453.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

BIRTHS

CANTY.—On February 7th, 1966, at Maltby Cottage, Barton-on-Humber, Lincs, to Mary and George Canty, a daughter, Catherine Ruth, a sister for George and Margaret.

ORME-SMITH.—On February 9th, at Queen Charlotte's Hospital, to Elizabeth Ann (née Ridley) and David Orme-Smith, a daughter, Victoria Helen, sister for Sarah, Charlotte Paul.

SHANNON.—On January 17th, at Sanling House, Hollesley, Suffolk, to Patricia (née Goldsworthy) S.R.N., and Colin Shannon, M.B., B.S., a daughter, Clare Margaret, a sister for Samuel and George.

MARRIAGE

TATFORD—DAVIES.—On February 19th, at Southwark Cathedral, Patrick Tatford to Norma Davies.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2025

PASSIM

The Final Rag

The activities before the Hospital Cup final may epitomize, for some, the ultimate in medical studentmanship. The plaster, brilliant coloured solutions and assorted missiles have become part of a hallowed tradition. The appearance of the churn with its security system, which could rival any national system, gives this occasion a unique importance. The tension building up before the match with the usual sorties into rival territory, culminates in the pre-match activities at Richmond forming part of the trappings of medical student life in London.

Student Rags have almost become part of the country's heritage, even though more recently they have suffered greater restrictions. The University Rags are usually aimed at supporting charity but the mêlée at Richmond has no such laudable function. It is purely a pointless exercise which perpetuates an out-dated medical student image. If the issue went no further it might be tolerated as a somewhat juvenile romp but, unfortunately, each year it has its own toll of accidents. This year was no exception and a fractured pelvis must be added to the list. At this price there can be absolutely no justification for repeating this useless and misguided horse-play.

This sort of violent activity from medical undergraduates is not only confined to the Hospital Cup final, or for that matter to undergraduates. There is a peculiar ritual that occasionally takes place on the House. The time is irrelevant, the occasion insignficant, but the pattern of the performance is essentially the same. The damage is paid for later by the housemen involved, when sobriety ensues.

The cause and need for this type of activity among medical trainees is questionable. It is hardly acceptable that they need this form of expression as a release from any frustrations in their work. Perhaps it is all a meaningless tradition, an act of irresponsibility aimlessly perpetuating itself beneath the cloak of medic folk-lore.

Guy's Art

The Guy's Art Society Exhibition was recently opened by Lord Brock in that honoured side-room of the Gordon Museum that contains the original pathological specimens of Bright, Hodgkin, Gull and Addison. All those who had the pleasure of seeing the Society's display were deeply impressed not only by the high quality of the work shown, but also by the fact that the contributors came from all parts of Guy's. Nurses, Students, Doctors, Medical Scientists and even Professors, were all exhibiting in oils, bronze, wood, wire and water-colours. The styles too ranged widely from the straight landscape to the abstract and in a significant number there was a well marked individualism that is the hallmark of truly creative artistic talent.

The collection and organisation of this display must have taken considerable time and energy and the organiser is to be complimented on his achievement. His efforts have not only afforded us with a rare enjoyment for yet another year, but also it must have come as a surprise to many people to know that such ability existed here and now at Guy's. Indeed, one is tempted to feel that there are far more talents at the hospital than most people suppose, but that the facilities and general emphasis on the more limited aspects of training, tend to keep them hidden. Nevertheless, at a time when so many sweeping generalisations are made about scientific philistinism it is gratifying to see that Guy's is not only capable of maintaining fine Theatre and Music Clubs but also of producing an exhibition such as that.

Mr. J. S. Tomkinson has been appointed Consultant Adviser in Obstetrics and Gynaecology to the Ministry of Health.

Dr. R. S. Wells has been appointed consultant dermatologist to the hospital.

Mr. F. G. Ellis, of the Department of Surgery, last year became the first Naffziger visiting scholar to the University of California in San Francisco and during his stay at the university he held the post of Assistant Professor of Surgery.

On Saturday, the 5th of March, the Guy's Dental Society held its sixtieth annual Dinner at the Park Lane Hotel, when Dr. R. A. Cawson was in the chair. Among the after-dinner speakers were Lord Robens, Professor Sir Robert Bradlaw, Professor D. J. Anderson, Professor R. D. Emslie, Mr. A. H. R. Rowe and Mr. N. H. James. Many members of the Board of Governors and the medical and surgical staff of the hospital were present.

In this week's *Gazette* we are including two articles that are perhaps worthy of special introduction. The first is "The Care of the Dying", by Dr. Cicely Saunders, who is perhaps uniquely qualified to write upon her topic. She has worked for the past seven years at St. Joseph's Hospice, where a proportion of the beds are reserved exclusively for patients with terminal disease and was trained as a nurse and as an almoner before reading Medicine.

The second is a short piece of Guy's history entitled "The Mystery of the Milk Can". We felt we should include this, following the topical interest aroused by Mr. H. V. Leigh's letter in the last *Gazette*. It is a careful account that was compiled by Mr. G. Winston, our former Wills' Librarian, some time ago while he was still at Guy's.

We regret that, owing to an oversight, we omitted to name Mr. M. Seeley and Mr. B. J. Bloice as co-authors of the article "Southwark and the Origin of Delftware", which appeared in the *Gazette* of March 5th.

GUY'S DIARY

MARCH			
Exhibition:			Obstructive Jaundice.
21st	M.	1.00	Clinical Lecture. Mr. ROSS. "The Scope of Vascular Surgery"
22nd	Tu.	1.00	Clinical Lecture. Dr. Stafford-Clark: " Psychosomatic Approach to Sex Life, III ".
24th	Th.	1.00	Clinical Lecture. Dr. HOARE. " Calcification in Diseases of the Nervous System".
25th	F.	1.00	Clinical Lecture to the Dental Students in the Dental Theatre. Mr. J. W. MANSIE. "Examineeship".
26th	S.	10.00	Clinico-Pathological Conference. Clinical Theatre.
28th	M.	1.00	Clinical Lecture. Mr. STAMM. "Manipulative Surgery".
29th	Tu.	1.00	Clinical Lecture. Professor ROY CALNE. "The Present Status of Renal Transplantation".
31st	Th.	1.00	Clinical Lecture. Dr. Stafford-Clark: " Psychosomatic Approach to Sex Life, IV ".
APRIL			
1st	F.	1.00	Clinical Lecture. Professor KNOX.

Mr. Tomkinson and Dr. Stafford-Clark are giving a course of Lectures on "Psychosomatic Approach to Sex Life". Dr. Stafford-Clark will continue the course on Thursday, April 14th.

THE CARE OF THE DYING

by

Cicely Saunders, O.B.E., M.A., M.B., B.S., S.R.N., A.M.I.S.W.

Formerly of St. Joseph's Hospice

"A dignified death proclaims the significance of all men."
Robert Fulton. Death and Identity[9].

The care of a dying person means such relief to his distress as will enable him to live as himself even while he is approaching death. It may be hard to decide when our treatment of a particular person has finally reached this stage. Here I will define it as occurring when the time for all active treatment is over and when a patient's will to live and fight to recover are beginning, by the very processes of illness, to be changed into preparation for and a movement towards death. Too often, one could also define it as the time when a doctor says, or feels, that "there is nothing more to be done" and he and others withdraw more or less subtly from real contact with the patient. Such a patient remarked to me on admission to our unit, "It seemed so strange, no one seemed to want to look at me."

The preparation for death usually takes place first in the subconscious, as Jung pointed out[14]. He added that he found that it makes astonishingly little ado about the actual fact of death, only concerning itself with *how* death is achieved. Here we are dealing with a criterion of success rather different from that usually found in our work. We have to look, not at the achievements of medicine and nursing but at what the patient himself is accomplishing in the face of his physical deterioration. Once we begin to look we are surprised by how much we see.

Some will perhaps find it shocking that we should talk thus of preparing for death and will think that both the patient and the doctor should fight for life right up to the end. But to talk of accepting death when its approach has become inevitable is not mere resignation on the part of the patient nor is it defeatism on the part of the doctor. Certainly they will take no deliberate steps to hasten the process but for both of them it is the very opposite of doing nothing. Proper care and control of distress should prevent the patient from reaching that desperate place where he may ask that we should hasten the end. Our work is to try to alter the character of this

stage of illness not only so that such distress should be relieved but also that this time is not seen or thought of as a long defeat of living but as a positive achievement in dying itself, a time for reconciliation and fulfilment for the patient and perhaps his family also. A clearer look at this would also help us to see the difference between prolonging life and prolonging the act of dying. It is not always easy to recognise that a particular patient is "beyond medical reclaim" and that our aim should now be comfort rather than cure or the maintenance of a travesty of life[7]. Only by a real awareness of a person in his wholeness is one able to meet his needs at this stage and also to keep open that loophole through which, with astonishment, one sees the very occasional, totally unexpected reversal of the process.

The Patient as Part of his Family

> . . . my patients
> Are only pieces of a total situation
> Which I have to explore.
>
> T. S. Eliot. The Cocktail Party.

Approximately half of the patients who die of cancer in Great Britain do so in their own homes[11]. For many of them it is the ideal arrangement. Many families are splendidly independent and adequate for this situation once they have grasped what is required of them. Others need to be told what the situation is, several times, simply and definitely, before they take in or believe anything at all. Practical arrangements and support will be needed at some stage in most cases of terminal illness at home[26]. The help of a caseworker will usually be invaluable. It is very important not only to time the provision of help but also to let the family know in advance that it will be available. An outsider may also be able to encourage all the members of the family to participate as fully as possible.

Families must be given some idea of what to expect, at least an approximate estimate of time and a description of the symptoms that may appear, with reassurance that they can be alleviated. Many people think that dying of cancer, indeed all dying, inevitably means pain and distress. They need to be told that the majority do not suffer sever pain, that many have none at all, and that almost all can be helped. We then have the responsibility for doing our best to see that such help is given when it is needed[10, 18].

Admission to a hospital or home may be imperative, but even then may not always be possible[26]. Unfortunately, the image in the mind of the public of distressing death has still too many foundations in fact[1, 16].

The patient who is admitted is still part of his family. In hospital as well as at home their distress and their corresponding need for a listener may be even greater than that of the patient. Grief, feelings of guilt and old, unresolved tensions may make them withdraw from real contact and communication with him and greatly increase the loneliness on both sides. The isolation of a dying man has never been better described than by Tolstoy in "The death of Ivan Ilych"[23]. By relieving physical distress and by listening to both sides we may have the chance to relieve some of the anxiety and help them to meet once

more. It is not rare for people to do so more deeply now than at any other time in their lives. This will greatly help the family through their bereavement.

Telling patients

"When the hospital said nothing, and my doctor said nothing, then I knew."—A patient with carcinomatosis.

Our attempts to help the family as a whole must include a consideration of the question of "telling the patient the truth". The usual practice is to inform the relatives of a poor prognosis but not the patient. It is certainly important that someone in the family should understand the position as the doctor sees it, but we sometimes underestimate the anxiety thus imposed. It is a great strain to guard continually against a careless word and it may be intolerable to carry the first unshared burden of a married life. Geoffrey Gorer writes of the grief and self-reproach this may cause[12]. We find that relatives are commonly more afraid of the patient knowing than he is himself. We can never impose openness upon those who do not wish it, but we can certainly reassure them that the patient will rarely be afraid when death finally approaches. Our experience agrees with Worcester, who says, "Death is almost always preceded by a perfect willingness to die"[27].

Every patient needs an explanation of his illness which will be understandable and convincing to him if he is to be relieved of the burden of unknown fears. The fact that he does not ask does not mean that he has no questions. One visit or talk is rarely enough to tell us what he is really thinking. Silences are often more revealing than words as we try to learn what he is facing as his illness progresses. The help he needs at each stage may be quite different. Hinton found that the great majority of 102 dying patients in a general hospital knew that death was more than likely even though they had not been "told", and the ward staff were often very surprised at his discoveries[13]. Our evidence would agree with his findings, but nothing can tell us what our individual patient is thinking and needing but our own eyes and ears and judgment. The real question is perhaps best expressed, "What do you let your patients tell you?"

The alternatives are not merely silence, bland denial or stark, fatal truth. There are many different facets of truth, just as there are many ways of imparting it. We have to learn to try and present the one the individual needs at that moment in the simplest and kindest way we can, leaving him the choice to take it or leave it as he wishes. One patient may be anxiously preventing us from assaulting him with information he is not able or willing to handle, while another has already come to terms with a hopeless prognosis but needs reassurance to dispel inaccurate and horrible apprehensions. So much of this communication will be without words or given indirectly. This is true of all real meeting with people, but especially true of the very ill and those who are facing, knowingly or not, difficult or threatening situations. Once the possibility of talking frankly with a patient is admitted it does not mean that this will necessarily take place but the whole atmosphere is changed. We are then free to wait quietly

for clues from each patient, seeing them as individuals from whom we can expect intelligence, courage and individual decisions. If they feel secure they will give us these clues when they wish[5, 6].

In such a setting people come to the place where they know they are free to talk as and when they are ready. When they are, they may seem to hold two quite incompatible views of their illness or to change from day to day. Often they will wait to talk until long after the illness itself has revealed to them what is happening. They may only do so when they have some specific questions to ask about their families. Other common questions are "Will it be very long?" "Will I get pain?" "Will it be in my sleep?" "What will it be like at the end?" We can be reassuring about these questions or answer them indirectly even before they are asked. If we are not there to listen, how much anguish may go unrelieved?

The Control of Physical Distress

"It was *all* pain."—A patient on admission to St. Joseph's Hospice.

This includes the alleviation of pain and many other symptoms. In these discussions we often tend to think only of patients with cancer and this concentration in our thought is probably because of the emotional impact still made by this disease. Although this may only be subconscious it often has more influence than we realise upon our dealings with our patients. We need to remember also those other terminal illnesses whose physical distress may perhaps be more difficult to relieve. Whatever the problem, its control must be begun in good time and continue right up to the end. There is no space here to discuss this fully but there are a few important principles, which can be described briefly.

These patients are usually suffering from a generalised disease of which the signs are not always very helpful. Such "total pain" calls us to analyse, to assess and to anticipate. We have to give attention to the details of this situation as it has its impact upon the patients and to treat each symptom, giving some explanation of what we are trying to do. As one patient put it, "I could have added at least one minim of faith to the dose if I had known in what direction to project my faith"[17]. Symptomatic treatment, so wrong when definitive treatment is possible, now becomes mandatory[4]. Patients rarely over-rate their distress, certainly not when their confidence is established, but they often find it hard to describe and semantic difficulties abound. We gradually learn the common difficulties. Such an approach gives a positive feeling to each visit, both this and the listening entailed are therapeutic in themselves.

We should anticipate distress and pain by our treatment so that the patient does not continually do so himself. This will help him to maintain his independence. If pain is constantly allowed to occur, each time the patient has to ask someone for something to relieve it. Not only does he then make it worse by his fear and tension but he is reminded of his dependence upon the drugs and upon the person who gives them to him. If they arrive regularly, in a dose balanced to his own need and covering adequately a somewhat elastic routine time, he can relax and forget the pain at last. The patient who said,

"It was *all* pain," went on to say "And now it's gone—and I'm free." (From a tape-recording).

It is possible to use the opiate drugs so that the dangers of tolerance and addiction are largely avoided and so that the personality of the patient remains in full alertness until the disease itself clouds his consciousness. Personality will be far more submerged by the fact or the fear of pain than by drugs properly handled to relieve it. The art of giving analgesics in this situation is to use those of which we really know the effects and side-effects, always in combination with adjuvants equally well known to us and coupled with adequate treatment of other symptoms. All these can be kept constantly at the patient's own optimum to the end [19, 20, 21].

Understanding and treating mental distress.

"Tranquil talk was better than any medicine;
Gradually the feelings came back to my numbed heart."—Po Chu-I
(9th Century A.D.).

The same principles of analysis, assessment and anticipation govern the use of drugs for the control of mental distress. Once again we need to handle a few well-known drugs in doses suited to the individual patient, bringing his burden into manageable proportions and thus helping him to be free to manage his own situation. As before, we need to begin in good time and not to wait for the crisis of panic or confusion. Small regular doses begun early will often avert them.

Mental and physical distress are interwoven but we have to do more than merely treat physical symptoms and give tranquillizers if we are to reach and help all the anxieties, the depressions and above all the feelings of loneliness, failure and guilt which are so commonly part of such illness. These people need someone who will listen and try to understand how they feel. They do not even ask for success in this but only that someone should care enough to try. The treatment of symptoms will make such listening easier. Where there is always something to try and do there can be something hopeful, or at least helpful, to say. Talk of symptoms can indeed be a way to avoid more difficult subjects but it can also be carried on in such a way as to give assurance on deeper levels, and to offer an opportunity for the patient to talk of his other problems when he wishes. If he can express some of them he will be helped to mobilise his own resources and handle them himself. We do not always realise how much of the power is drained out of fears by the very act of expressing them to someone else. Suffering of all kinds is greatly intensified by isolation and it is difficult to believe how much a short, frequent visit can help or how desperately its omission is felt.

"Feelings are facts in this house," as one of the nuns at St. Joseph's Hospice expressed it. They are often the most powerful facts in the whole situation and must be accepted as such. They are not all sombre or even solemn. The man who is asserting his independence to the end in splendidly exasperating fashion, the incongruous and

the frankly funny are all part of such work. So also is the amazing lightheartedness of someone who has shed ordinary cares and come through doubt and fear to the place where the whole situation is deeply accepted.

There are types of distress which should rightly be termed "spiritual". Real liaison by the doctor himself with the priest or minister of the patient's choice may be most important. As always, liaison is best where it is personal, informal and continuing. Where possible it should start early and it can be of immense help to the whole family. It is impossible to suggest this where there is no understanding or willingness on the part of the patient, but we will often be surprised how welcome it is when introduced with care and courtesy.

I would like to interpret our responsibility more widely and stress the demands it makes upon us to try and bring some sense of meaning and security into this situation. Meaninglessness is harder to bear that almost anything[15]. Our regard for our patient will not allow us to impose our own faith or philosophy upon him but unspoken confidence and conviction can reach him and help him to find his own key to meaning. This is one of the reasons for the comfort that is often given to these patients in a Home where a staff have chosen such a work and had time to think deeply and feel positive about it.

Those who have no place for the fact of death in their thinking are not looking very realistically at life and do not find it easy to remain long with the dying. "In the last analysis, it is our conception of death which decides our answers to all the questions that life puts to us." (Dag Hammerskjold). To refuse to reflect on such matters is to go against our nature and our roots in the past. A search for interpretations that are relevant in today's world is important and illuminating both for those who find the traditional expressions meaningful and those who do not. We can learn from Frankl[8], a psychiatrist, who found a purpose and meaning in life and death in Auchwitz and from Teilhard de Chardin[3], whose breadth and depth of thought brings a cosmic awareness to the individual man's own problems of dealing creatively with what he terms "the passivities of life" and "the diminishments of death". Tillich analyses the present impact of "existential anxiety", the anxiety implicit in man's very existence with all its inevitable negatives and finitude and its demand for what he calls "The Courage To Be"[22].

We need to read such thinkers but in the end we will perhaps learn most by looking at our patients. What they ask of us is the true meeting between persons described by Buber in "I and Thou"[2] and by Tournier in "The Meaning of Persons[24]. If we are able to meet them like this it is more than likely that we will be those who gain and learn most from the encounter. They meet us both as the essential persons they are and also as part of an infinitely important situation of which we have to take cognizance. If we are prepared to look at them in this way we will learn a great deal more than we may expect concerning the whole of medicine and indeed the whole of life.

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CORRESPONDENCE

The Hospital Rugby Cup Rag

SIR,—I am the oldest man who was ever a medical registrar at Guy's. I am probably the oldest man who ever captained Guy's at cricket, and the same may be said of Association football.

In my time we had a very distinguished Rugby team which we went to watch with true sporting enthusiasm. There was no "rag" which might detract from the skilful game.

When I looked in the *Times* this morning for the result of the Rugby final, the report was chiefly concerned with the rag. That would have been an insult to the team in my time. Is it possible that the rag has gone on long enough and that it might be dropped?

Rabelais spoke of a span of life equal to that of one dog and three cows. If I have nearly reached that of one dog and four cows, do you think it is reasonable for me to give an opinion at all?

HUGH BARBER,

Derby.

The Not-so-Super Structure

SIR,—I should like to comment on your articles, "The not-so-super Structure" [Passim, 19th Feb., 1966.] It seems that the article, when stripped of its padding and illogicalities, boils down to this:—

It proposes the theory that an exaggerated and unnecessary charade of hierarchy exists at Guy's, and gives the reasons for it. These are: a jealous protection of privilege, position and ambition, a lack of contact due to commitments of medical work, and a deliberate maintenance of "tradition" of superiority, however slender. All this, claims Passim, leads to an unhealthy atmosphere of selfishness and "kill or be killed" on one side and a stifling of "free intellectual exchange" on the other.

Is this, in fact, the case, though? I accept the article's proposition, despite its qualification, hedgings, and painstakingly provided escape clauses; but the reasons for it, and the results attributed to it by your author, seem to me to be unnecessarily complex, and more than a little embittered and cynical.

I am inclined to think that the fault lies simply in the personality of the offenders (on both sides of the qualification fence!) who perpetuate the system, rather than in the system which perpetuates the personality. There are some people who have to "lord it" over others on gaining even the slightest superiority of position; equally, these are those who no matter how high they rise, retain a sense of proportion, humour, and understanding, towards those about them. Unfortunately, it is not those who hide their arrogance under the shield of "tradition" who are considered unusual.

And this leads on to another point. Are not too many students so conditioned by "schoolboy law" that on arriving at Guy's, we accept the situation meekly, instead of making our superiors show their mettle, and thus justify their position? This is a better solution than a revolution, and if it were coupled with a more searching assessment by the powers that be, of staff before they are appointed to posts involving teaching and discipline, would speedily resolve the situation.

So in the meantime, let us not oust the registrars from their little breakfast table in the Spit—after all, Churchill always breakfasted apart from his wife, a person of considerably more charm and intelligence than the average student (at that time of morning anyway!).

Yours, etc.,

IAN HINE.

East Wing,
Guy's Hospital.

A Point of Persuasion

SIR,—The successes of acupuncture and other unconventional methods of treatment if one remembers that hysteria may afflict seemingly unlikely people, has protean symptoms and can be grafted in organic disease.

The late Sir Arthur Hurst, when Radcliffe Travelling Fellow in 1907, visited Babinski's Clinic. He says in his autobiography (*A Twentieth Century Physician*), that Babinski said every case of hysteria was curable by reversing the process which had given rise to the symptoms. He proceeded to cure the patient as soon as the diagnosis had been made. He used various sources of suggestion, especially painful faradism, together with vigorous persuasion. These methods were extremely successful. Hurst on his return to Guy's, used similar methods with good results, but substituted explanation, persuasion and re-education for suggestion. These methods were used with conspicuous success in the many cases of hysteria among soldiers at the Seale Hayne Hospital during the first World War. I saw Hurst treat a soldier with almost complete hysterical blindness, loss of all central vision. He had him reading capital letters in about ten minutes.

Hurst sometimes demonstrated to students at his Neurological Outpatients that any suggestion that the patient believed, however silly, would serve. For instance, one day a cabby turned up complaining that if he shut his eyes he could not open them unless he pulled his nose. However hard he tried he could not. This worried him because the men on the rank made fun of him. Hurst told him that if he pulled his thumb it would work just as well. It did, and the man went off happy, he could pull his nose unobserved.

With acupuncture we have the needles instead of Babinski's painful faradism and all the fandango about placing the needles fortifies the suggestion.

Anyone interested will find much about hysteria in "Seale Hayne Neurological Studies", edited by Hurst, which I am sure must be in the Wills Library.

Yours, etc.,

E. W. SHEAF.

Lark's Hill,
Longdown,
Guildford.

Hot Line

SIR,—May I, through your columns, compliment the staff who answer the telephone at Guy's on their unfailing efficiency, most welcome to a harassed and impatient G.P., and a complete contrast to some other London teaching hospitals I could name.

Yours, etc.,

W. H. BARKER.

11, High Street,
Stevenage,
Herts.

NOTICES

Guy's Hospital Society

SOUTH WALES MONMOUTHSHIRE BRANCH.

The 15th Annual Dinner will be held at The Park Hotel, Cardiff, on Saturday, 26th March, 1966, at 7.0 p.m. for 7.30 p.m., the evening of the Wales v. France International Match at the Cardiff Arms Park.

Your President will be Mr. Hugh Harley, F.R.C.S., and I hope you will give him your support and make this dinner the best ever.

Guests: Professor Hedley Atkins, D.M., M.Ch., F.R.C.S., and the Appointments Officer, Guy's Hospital.

Dress: Lounge Suits—Officers to wear Dinner Jackets, and others if they wish. Tickets £1 12s. 6d., exclusive of wine, plus 10s. membership to the Society. All Guy's students (old and new) welcomed. Applications for tickets to: Mr. G. Morwent Brown, 4, Plymouth Road, Penarth, Glamorgan.

The Debating Society

A large audience of well over eighty nurses and students crowded into the North Common Room on Tuesday, the 8th of March, to hear the motion debated that " This house considers that the reputation of a Medical Student is easier to live up to than to live down." The speakers for the motion were Dr. Murray Brookes and Miss Anna Maria Tinanyi, and those against were Dr. W. L. Gent and Mr. Richard Savage. Dr. Betty Coles was in the chair. There were numerous lively speeches from the floor, and the final voting was 43 votes for the motion and 31 votes against, with 7 absentions. The Society invited the house to coffee and biscuits after the debate.

The Music Circle

At the A.G.M. of the Music Club it was decided to form a Music Circle, the intention being to talk about, listen to and perform music. The meetings will be aggressively informal, each with a musically interesting topic. The first will be on April 5th at 8 p.m., in the Music Room in the East Wing.

Everyone connected with the Hospital is welcome. If sufficient enthusiasm is forthcoming, then London musicians will be invited to talk to the circle and parties to concerts arranged. For the existence of such a circle, individual contributions are essential, and anybody prepared to talk about any work, instrument, composer, etc., should please contact either Hedley Berry or Michael Coe by East Wing pigeonhole or directly in the College.

MICHAEL LINDOP, Hon. Secretary.

Athletic Club Dinner

The Athletic Club will be holding its annual Dinner on Wednesday, 6th April. Tickets (one pound) are available from D. Barford or myself.

J. DOMAINGUE (Hon. Sec., G.H.A.C.)

Boat Club Bumps Supper

The Boat Club is holding a Bumps Supper on May 13th at the boat-house of the London Rowing Club, at Putney. The occasion marks the last night of the United Hospitals' Bumping Races.

The object of the supper is to contact *all* old members of the club, no matter how recently or how long ago they rowed. I will be sending formal invitations to all those members who have recently contacted me, but I would be very grateful if people whom I have not already written to, would drop me a post-card.

The evening promises to be most enjoyable, and not only will you be made very welcome by presently active members, but we hope that you will be able to renew contacts with contemporaries.

JONATHAN WILLIAMS (Hon. Sec.)

Sports Day: Preliminary Notice

Guy's Hospital Athletic Club are to hold their Annual Sports Day on Saturday, 11th June, 1966, at Honor Oak Park. There will be a varied programme of events, both athletic and otherwise, in the afternoon, followed by a barbecue and dance in the evening. Further details will be announced at a later date.

L. J. TURNER (Sports' Day Secretary.)

HYPNOSIS

by

Stephen Stanley-Little

Although the state and phenomena which we would now describe as hypnotic have been known under various names and in many cultural settings in the past, the scientific study of hypnosis is relatively recent. Still more recent has been its acceptance by the scientific community as a useful contribution to psychology and psychiatry. Partly due to professional conservatism, the main responsibility for this lies with the theatrical exploitation of the possibilities inherent in hypnosis which inspired professional mistrust and the false beliefs of the uninformed.

Anton Mesmer (1733–1815) is usually accepted as the first proponent of hypnosis as a therapeutic technique in the western world, despite the fact that there is little evidence to show that he ever induced a true hypnotic state as we know it[1]. The cures which he obtained, mostly in hysterical patients by means of abreaction, may be ascribed to the use of suggestions in susceptible subjects in an atmosphere calculated to maximize their effectiveness. Indeed, the methods which Mesmer used to heighten this atmosphere, the flowing robes and majestic presence of the maestro, the softly played hidden music, while reminiscent of religious rituals and techniques from the devotees of Aesculapius to those of Nôtre Dame at Lourdes, were primarily instrumental in discrediting him and his work in the eyes of the medical profession of his time. The latter, while exposing the quackery, quite failed to notice the important thing, that people were being cured. His disciple the Count de Puységur systematized Mesmer's observations and can claim the credit to be the first to describe the narrowing of attention in the hypnotic trance: the unquestioning acceptance of suggestions and post-hypnotic amnesia.

Faltering interest in these phenomena was revived by Braid, a Scottish surgeon working in Manchester in the 1830's, regarded by some as the founder of the scientific study of hypnosis. At first interested by a public demonstration of Mesmerism he was able to induce auto-hypnosis by staring fixedly at a bright light, a phenomenon known as Braidism, which thus killed Mesmer's idea of a flow of animal magnetism from therapist to subject responsible for the

Mesmeric state and for his startling cures. Elliotson, at University College, London, and Eskdaile, in India, demonstrated the possibility of operating under hypnosis in the days when alcohol and opiates were the only anaesthetics. The advent of chloroform, however, suppressed nascent enthusiasm for the technique seconded by the feeling that chemical anaesthetics were somehow more respectable because, being more "physical" they appealed to Victorian materialism ever ready to degrade what it could not understand to the level of spiritualism.

Although these prejudices encouraged a sensational approach to hypnosis which relied almost exclusively on the demonstration of hypnotic phenomena, exploration of their therapeutic possibilities continued unobtrusively until in recent years several societies have been set up which enshrine the principles and practie of hypnotherapy: its use has become standard in many branches of medicine. By contrast, the study of hypnosis qua psychological phenomenon is less advanced and is not included in the curricula of most British Faculties of Psychology.

A paper of this scope cannot hope to give more than a brief account of the nature and phenomena of hypnosis. There appears to be no generally accepted definition: tentatively one may suggest "a state of the organism characterized by a reduction of attention-span and increased effectiveness of suggestions (no matter how defined)"[2]. Hypnosis is induced ordinarily by relaxing the subject on a couch in a quiet, dark room; tiring his eyes by getting him to concentrate on a source of light or pencil-point just inside the nearest point of comfortable convergence; by suggesting that his body is relaxed, his eyes are tired, he is breathing regularly and deeply, etc., in a monotonous low voice until the patient, in some techniques, cannot open his eyes or lift his finger at command when this is suggested. He is now in a light trance, which can be deepened by suggestion. The trance can be terminated by bringing the subject through lighter and lighter stages of "sleep" until he is fully "awake". Hypnosis differs from real sleep in which suggestions are ineffective (attention is either in abeyance since it has no object or confined to subconscious material: dreams may be an expression of that sphere of memory and experience not subject to present awareness or capable "ordinarily" of recall. This becomes relevant for the hypermnesia of hypnosis, as we shall see). Again, EEG studies do not differentiate hypnosis from the waking state. Indeed it is related to everyday states in which we say someone is distrait or in a brown study: these states of reduced attention are either spontaneous or can be the result of maintained concentration. A definition, however, which seeks to define hypnosis in terms of those stimuli which induce it tends to fall into the trap of irrelevance: there are remarkably few factors which seem necessary and sufficient for induction: it is well-known that people can be hypnotized in a noisy room in the presence of many others.

With this proviso, we may describe the degrees and phenomena of hypnosis. The former are often defined by whether the latter are present or not during the trance:

(1) the lightest or hypnoidal phase, defined by relaxation, fluttering of the eyelids, and eye closure leading to complete relaxation;

(2) light trance, by inability to move the limbs or open the eyes, rigid immobility and glove anaesthesia;

(3) medium trance, by partial amnesia for the events under amnesia, simple post-hypnotic suggestions and anaesthesia, personality changes;

(4) deep trance, by the ability to open the eyes without affecting the trance, bizarre post-hypnotic suggestions, hypnotic and post-hypnotic hallucinations, both positive and negative, systematized post-hypnotic amnesias.

The relative percentages of people falling into these categories are roughly 15 per cent insusceptible; 40 per cent fall into a hypnoidal or light trance; 25 per cent a medium trance; and 20 per cent into a deep trance[3]. These figures should be accepted with caution since practice effects as well as variables such as the personality and methods of the hypnotist are not taken into account. Apart from the above phenomena there are others in which normal abilities appear to be greatly increased: hyperaesthesia and hyperpraxia (increased acuity and intensity of sensation, increased muscular performance) and hypermnesia: the latter is of special interest to the psychotherapist, in so far as material repressed and/or no longer capable of recall appears to become more accessible.

The question arises whether these abilities, both positive and negative, are an exaggeration of the normal or arise de novo. Whereas it appears probable that the former explanation is true in so far as they are explicable in terms of increased attention, in which the subject is working at capacity, and, in the case of analgesia, in terms of "guided inattention", this theory cannot explain regression to childhood in which reflexes seen only in childhood appear over which the subject would be expected to exert no control, or the execution of suggestions in hypnosis against a suggested appropriate background where these would ordinarily be repugnant to the subject; some theory of dissociation à la Charcot would appear to be required here.

Lack of experimentation necessarily limits our ability to understand the basic processes involved. It is easier to understand how the phenomena just described are brought about under hypnosis than how hypnosis is induced for the first time. For example, an explanation in terms of conditioned reflexes adequately accounts for post-hypnotic suggestions and re-establishment of a trance at the suggested signal, but not for the initial establishment of the trance state. Again, some conceptual model involving an attention mechanism sorting out signals and concepts, suppressing some and amplifying others relative to each other with consequent dissociation for example, would seem

to be necessary, but does not show how this mechanism comes under the control of the hypnotist in some cases and not in others. Explanations put up to account for this in terms of suggestibility tend to be circular depending on how one defines hypnosis (e.g., the deep trance subject is often said to be very suggestible, the only evidence being that he is capable of a deep trance). It is well known, however, that primary suggestibility (as measured, for example, by the body sway test) is correlated with hypnotizability, whereas secondary suggestibility (as in the memory suggestion test) is not.

Like any other psychological phenomenon, hypnosis has its uses and abuses. As pointed out initially, the inherent possibilities of a situation in which a man can be made to behave in a manner quite alien to his normal self at the command of the hypnotist has been fully exploited on the stage, but only recently have its therapeutic implications been explored. One of the earliest applications of hypnosis, as pointed out above, was the production of anaesthesia during surgery. Revival of interest in this field in recent years has occurred in three situations: surgery, dentistry and obstetrics. Hypnotic anaesthesia has obvious advantages here: it is much cheaper than chemical anaesthetics, has no after effects and is not subject to the contra-indications to the latter, such as chest infections, or to its complications such as the inhalation of vomit. On the other hand, it should be emphasized that only 20 per cent of the population at the most are capable of a trance sufficiently deep for surgical purposes. In view of these facts the more widespread use of hypnotic anaesthesia in surgery would seem to be worth investigating. The use of hypnosis in dentistry is much more common and is also not limited to the elimination of pain, but is responsible for reducing tension and anxiety, for relaxing facial muscles and drying up salivary secretions during dental surgery. Significantly, the use of hypnosis in reducing anxiety during these procedures may play a direct part in reducing pain itself, thus reinforcing the popular impression that relaxation and concentration on some other topic can greatly reduce the pain of fillings for example. This factor is very much uppermost in obstetrics: hypnosis can be used directly during labour to reduce pain, or indirectly to reduce anticipatory anxiety; the latter probably being an important part of psychoprophylaxis or child-birth without fear.

Hypnotherapy is of great use in the treatment of a broad range of diseases usually called psychosomatic. It is significant that in asthma, eczema, peptic ulcers and other ulcerative-allergic conditions of the skin and alimentary canal, in migraine and gynaecological conditions, anxiety is often implicated as a primary or exacerbating factor. Thus the anxiety of the asthmatic during an incipient attack may quickly convert it into an emergency, perpetuated by the anxiety that worse is to come. Appropriate use of hypnotic suggestions can break this vicious circle. It must be emphasized that hypnosis is no substitute for medicinal treatment: like this, it has its indications, of which the presence of anxiety in the aetiology is the most important.

It is basic psychodynamic teaching that at the root of every neurosis lies a conflict between several action tendencies. The anxiety thus produced may be compensated in many ways, for example, by compulsive behaviour, by the exhibition of hysterical symptoms, by specific phobias. It may, however, remain relatively uncompensated, appearing as free-floating anxiety. Depression may complicate any or all of these situations. The rôle of hypnosis in anxiety states is twofold: firstly, to eliminate anxiety by suggestion during the trance; secondly, to use hypermnesia and regression to gain insight into the basic conflict. The form of treatment for this anxiety therefore is medicinal combined with graded deconditioning of anxiety both when this is generalised and when it is crystallized around specific concepts or situations, as in phobias. Hypnotic suggestions in this form of treatment, an example of which is given below, primarily reduces the anxiety aroused and secondarily maintains the patient's confidence, feeling of control over the situation and well-being during this relatively direct attack on the situation. This is achieved by means of appropriate suggestions at the induction of the trance; often accompanied by a code-signal in the form of a post-hypnotic suggestion such that the patient can experience a feeling of calm and confidence by using the signal when threatened by an anxiety-arousing situation.

A stock objection to this application of Wolpe's theory of systematic desensitization[4] is that it fails to resolve the initial conflict of which the anxiety is an expression. In practice, however, the prediction often made that another symptom should arise to replace the deconditioned phobia or hypochondriacal symptom removed by hypnotic suggestion appears unconfirmed. Hypnosis can further be used to uncover these basic conflicts and as such the hypermnesia and regression that can be produced under hypnosis have their place in interpretative psychotherapy as hypnoanalysis. With or without drugs, hypnosis may help to sidetrack, for example, the resistance of the patient with an hysterical conversion symptom to perceiving the conflict of which the symptom is a partial resolution by suggesting calm while getting the patient to act out or even automatically write out the conflict. It should be emphasised that no hysterical symptom can be entirely removed by hypnotic suggestions without the risk of symptom substitution until the basic conflict has been thoroughly explored. Unfortunately, obsessional states which cause as much distress to the patient as the other neuroses described above are rarely subject to effective treatment by hypnosis.

The great advantage of hypnosis is thus seen in the control it gives the therapist over the emotional manifestations which accompany and follow the discovery or removal of symptoms and conflicts. It is an extremely flexible technique which makes it possible for repressed emotion to come out at a rate and to an extent suitable for therapeutic progress without harming the patient's self-esteem or chance of recovery. If the revelation of a conflict under hypnosis produces an uncontrolled flood of emotion which cannot be integrated

into the patient's total personality structure, the appropriately suggested post-hypnotic amnesia for these events enables the therapists to delay their integration until the patient is ready for it. There are, however, contra-indications for the use of hypno-therapy and hypno-analysis. One of these is the presence of depression. Release of depressive affect not only destroys concentration on the task at hand but may also worsen the patient's state of mind between sessions. For these reasons, it is common to relieve depression before initiating treatment by appropriate anti-depressants or ECT. Another contra-indication is incipient psychosis, affective or schizophrenic, which is easily converted into the florid state by inappropriate suggestions.

Whereas hypnosis used as an interpretative technique in hysterical states usually requires the induction of a medium to deep trance and hence is limited in its applicability and in the number of therapists available to use it, as a supportive technique and means of controlling anxiety in the treatment of phobias, hysterical and anxiety states, and psychosomatic illnesses, a light or hypnoidal state is all that is required. Because of this, a technique has been evolved at Guy's Hospital which is available to all patients and therapists with a minimum of hypnotic training: this has been called "relaxation under light hypnosis"[5]. Essentially this consists of a *preliminary explanation* of the goals to be reached in each session and over all, together with discussion of misgivings the patient may have about hypnosis and problems that arise during treatment; followed by the *procedure for induction*—this is no different from any other technique for induction except that, importantly, no challenge of any kind is introduced, such as that the patient will be unable to open his eyes or lift his arm as a test of the depth of trance obtained. Such challenges often increase the anxiety of a nervous patient, especially if he finds he is, in fact, able to open his eyes, and this directly opposes the aims of the technique. A darkened, quiet room is used, a near fixation point —point source of light or pencil—being optional. The patient is then taken through the *five stages:* these essentially contain suggestions in a quiet, reassuring and repetitively monotonous voice from the therapist :

(1) *relaxation,* characterized by complete immobility, quiet breathing and a relaxed attitude;
(2) *calmness,* a subjective deepening of relaxation;
(3) *confidence,* which feeds back to the patient, already lightly hypnotized, the credit for having achieved this state;
(4) *control,* over and release from the symptom of which the patient complains: this is, of course, the most important part of the procedure and it is vital to feed back calmness and confidence at this stage and to emphasize the patient's credit for achieving relief;
(5) *well-being,* the total result of the procedure, is suggested as a taste of the total improvement the patient may expect.

The whole session can be rounded off by going back over the five stages in reverse order and bringing the patient out into a state of

alert, refreshed well-being by counting down from five to one, thus avoiding residual drowsiness or fatigue. The whole technique is simple and requires only a light trance. After the initial few sessions the whole process can be simplified to emphasize the stage of control at the expense of the others, without, of course, jettisoning them altogether. Finally, the patient learns how to use the technique for himself when and where appropriate.

A case treated with this technique may be quoted. Mrs. G., a housewife aged 30, was referred by her own doctor in May 1965, with a six-year history of phobic anxiety state centring on eating in public places, with friends in their home or her own, travelling in public transport and ultimately on leaving her house altogether, although she never became entirely house-bound. Anticipation of having to do any of these things produced great anxiety and would result in her using any excuse to avoid the situation; on the other hand, little anxiety was experienced if she did not know in advance that she would have to enter any of these anxiety arousing situations. There was a history of parental discord and progressive disintegration of her family circle during adolescence with the successive departure of her half-brother, sister and mother, culminating in a successful attempt to free herself from an irascible and demanding father.

She married in 1957 and had experienced symptoms on and off since her first pregnancy two years later. There was also considerable friction with her mother-in-law and more than a suggestion that her husband, a bank manager, was neglecting her for his work and weekend hobbies. Added to this, the strain of continually moving house produced an exacerbation of her symptoms such that by February 1965 she was practically house-bound Her husband's unsympathetic attitude made her situation less bearable than it would otherwise have been.

She was admitted to the York Clinic in November 1965, and a medicinal regime of Tryptizol and Librium was started to remove marginal depression and anxiety. A hierarchy of anxiety producing situations was constructed in order of severity :—

(1) any meal alone in a restaurant;
(2) eating a meal in the home of friends;
(3) eating a meal with friends in a restaurant;
(4) eating a meal with guests at home;
(5) travelling on public transport alone or accompanied.

A course of ideational desensitization was then started[6]. She was relaxed under light hypnosis and suggestions were made that she would be able to envisage herself travelling on a bus without anxiety; then in later sessions she would be able to envisage herself entertaining guests to dinner without anxiety and so on up the hierarchy

until she was able to envisage all of these things without experiencing any panic whatsoever. The next step was to carry out these procedures in actuality using a code word if anxiety was aroused, always in the company of her husband or a nurse. After ten sessions she was able to carry out all the procedures in the hierarchy without anxiety, except eating a meal alone in a restaurant. Since this was a rare event in her social life, it was decided to postpone desensitization in this area until a later date if necessary. She was therefore discharged, to this extent symptom free, a month after admission; in view of her vulnerable personality she is being followed up under the closest out-patient supervision. It was also thought that her long-term emotional stability depends to a great extent on establishing a closer rapport with her husband and a more settled way of life.

Hypnotherapy is therefore one technique amongst others useful in the treatment of illnesses in which anxiety plays a subsidiary or major part.

Outside the therapeutic situation, the application of hypnosis is still in its infancy. For example, hypnosis can be used to embed experimental conflicts into the minds of suitable subjects in order to study and confirm current theories of neurosis, dreams and personality defence mechanisms, much in the same way as other aspects of personality such as aggression and the sexual drive have been evaluated by thematic apperception tests. Thus a volunteer can be subjected to various forms of frustration and his subsequent aggressive fantasies will express themselves in dreams or in his reaction to a neutral picture; hypnotically induced conflicts can be more exactly defined and more "real" to the subject than any that can be produced in a non-hypnotized volunteer, who feels protected by his volunteer status and must always be aware of the artificial nature of the experimental situation. Perhaps most stimulating of all, the wholesale interference with the attention mechanism implied by hypnotic phenomena such as positive and negative hallucinations is of great importance in our understanding of allied situations where hallucinations are experienced, such as sensory deprivation and schizophrenia, and thus casts light on how the brain organizes stimuli, suppressing some and amplifying others on the transient screen of consciousness.

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THE MYSTERY OF THE MILK CAN

by G. A. R. Winston

In 1925, the Bicentenary Number of Guy's Hospital *Gazette* contained an absorbing short history of the Rugby Football Club by Dr. A. A. Allport, which included a chapter on " The Coming of the Milk Can." It was stated that on 12th March, 1908, the milk can was captured at Vauxhall Station on the journey to Richmond, when Guy's met The London in the Inter-Hospitals Cup Final.

The descriptive report stated that as the train from Waterloo to Richmond came to rest at Vauxhall Station against the signals. Norman Heegaard Warner, Reggie Crowle (*this should be Curle*) and Allen Coulter Hancock seized a milk can and the trophy was borne by the trio to an open carriage as the train was on the move.

At Richmond Station, the report continues, it was carried in the middle of a solid phalanx and so to the field of play, where it was displayed in a march of triumph.

The accuracy of this account of the milk can was never challenged until it was reproduced in Guy's Hospital *Gazette* in 1954 (pages 353-354). There were strong protests from a number of correspondents that the description of the incident was incorrect. This group, all of whom claimed to have been present when the can was captured, were emphatic that it happened at Vauxhall Station on the journey from Richmond to Waterloo, and 1909 was the year generally agreed upon.

The correspondence was led by F. C. Hunot (Guy's Hospital *Gazette*, 1954, **68**, 395), who said that he was inspired to write as true an account as possible because the one that appeared in the Bicentenary Number was palpably incorrect, and it was ridiculous to state that the train from Waterloo to Richmond stopped at Vauxhall only a few hundred yards away, and that the can was taken to Richmond.

On the contrary, he said, it was the practice at that time for local trains going to Waterloo to stop at Vauxhall for ticket collecting, and this procedure took some time and was thorough. It was during one of these stoppages, Hunot declared, that Jim Mudge, a large Cornishman, jumped out of the train and carried the selected *churn* into the compartment, and claimed that Mudge was the originator of the idea. He thought Guy's won the cup the year this incident occurred.

NOTE: Guy's lost to The London in 1908; beat Middlesex in 1909, having beaten The London in the semi-final, and beat The London in the final of 1910.

Of those in the compartment on this occasion, Hunot was not very certain, but thought Allen Hancock was there with G. D. Eccles, as they were always together, and possibly Reggie Curle.

Hunot gave a descriptive account of the procession from Waterloo to Guy's under police escort, when the *churn,* as he called it, which had started on almost ground level for concealment, was proudly hoisted shoulder high. On reaching the hospital the *churn* was placed on the bracket in the smoking room, where the cup rested when at Guy's, but later was relegated to the Pavy Gymnasium and soon forgotten.

This was followed by a communication from Norman Stephen Heegaard Warner, who claimed that he and W. E. (Bill) Tanner, with a number of medicals and dentals, were the *robber band*, and that they were in the next compartment to Hunot.

He agreed with Hunot's description of the triumphal march back to Guy's, but persisted that the milk can was captured on 12th March, 1908, at Vauxhall Station on the journey to Richmond, when the train stopped against the signals. It was taken under student escort to *Old Deer Park* from Richmond Station before the match in which The London Hospital beat Guy's.

Heegaard Warner described other incidents of that memorable day which may be of interest to support the accuracy of his claim. He mentioned, in a personal communication, that The London Hospital supporters marched on the ground wearing police helmets, and in the ensuing struggle with Guy's supporters, Heegaard Warner claimed a helmet as a trophy. Also that evening, he continued, the suffragettes raided the House of Commons, and next morning the courts were busy sentencing the many ladies to terms of imprisonment.

There appears to be strong support for Heegaard Warner's claim because, in Guy's Hospital *Gazette* (1908, page 102) "Passim" wrote as follows: —

> "*We join our wishes with those of the gentleman with a blatant voice and huge megaphone who, seated on a milk can, asked the world in general who would win in* 1909, *and then, with a voice Tartarean in its intensity, informed the aforesaid world in general, and the Richmond railway porters in particular— Guy's.*"

The mystery of the milk can deepens with the statement of Alan V. Moberly, a member of Guy's XV. He disagreed with many of Heegaard Warner's statements and was convinced that the milk can was captured in 1909 on the return journey from Richmond, and never saw Richmond till 1910, when it was hung on the goal posts.

Moberly agreed with Heegaard Warner over the policemen's helmets and described the arrival of The London students in open top buses. As they pulled up by the high walls, a horde of policemen, so it was thought, leapt down from the walls and were chased by the unfortunate gatekeepers to try and get their entrance money. Enquiries at The London Hospital have failed to confirm this amusing incident, although a number of London men of that time have been consulted.

A further remark by Moberly was that the late King George V, then Prince of Wales, was present, and " he thoroughly enjoyed the rag which followed."

NOTE: In the 1908 final between Guy's and The London on 12th March, Royalty is not reported to have been present.
In the 1909 semi-final between Guy's and The London on 24th February, Prince of Wales attended.
In the 1909 final between Guy's and Middlesex on 16th March, Prince Francis of Teck was present.
In the 1910 final between Guy's and The London on 9th March, Prince of Wales attended.

Moberly was convinced that 1909 was the year the milk can came to Guy's because that was the only year he did not play in the final.

NOTE: *Moberly came to Guy's in October,* 1907; *played in his first final in* 1908; *did not play in* 1909 *as he was injured, but played in the other finals while at Guy's, so he was a spectator in* 1909.

The next letter in the *Gazette* was from Reginald Curle, who said, as one originally concerned with the capture of the *Milk Churn,* he agreed that the contents of Alan Moberly's letter was perfectly correct.

Curle also described the stoppage of the train at Vauxhall for the collection of tickets, and it was during this wait that he and Bill Hancock jumped out, took the *churn,* and were hauled back into the carriage by Jim Mudge. Amongst others in the compartment were Alan Moberly, Jamie Stewart, Pinkie Hunot, G. D. Eccles and possibly Christopher Dean.

The next correspondent was Harry J. Hoby, who agreed entirely with Moberly, and that he was in the same compartment. He had also met Bill Hancock, who agreed with Moberly in all details. He also said that Hancock mentioned that the name should be *milk can,* although the word churn had been used for many years.

NOTE: *Harry J. Hoby was a member of the Rugby XV and played in the finals of* 1908 *and* 1909.

In a personal communication, Allen Hancock said that in his day the trophy was always known as the *milk can,* and that it was he who actually took the can, and Reggie Curle helped him to carry it and force it into a packed carriage at Vauxhall Station coming up from Richmond. It was all a bit of fun on the spur of the moment, and the can was taken back to *The Spit,* the lower smoke room of the College. He was not certain of the date, but thought it was 1909. In a later communication, Hancock thought the can might have been taken from Vauxhall in 1908 and that it remained dormant for a year and was taken to Richmond in 1910. Who took it to Richmond, Hancock was not sure, but he had the pleasure of hanging it to the crossbar, as will be seen in the picture taken by the *Daily Mirror.*

The first date inscribed on the milk can is 1909, but this does not necessarily mean that the milk can came to Guy's that year. It is probably the first year the cup was won after the milk can was captured.

Heegaard Warner has given the precise match and date on which he claims the milk can was captured, and this is supported by the note in " Passim " that a milk can was at Richmond in 1908.

The other correspondents have failed to give a date in 1909, and have not even mentioned who Guy's opponents were or the particular round of the cup.

It must remembered that Guy's and London met in the semi-final in 1909, and it has generally been inferred that the can was captured on the day of a final.

In an effort to solve the mystery of the milk can, and to establish the origin of Guy's famous trophy and mascot, careful examination of the various statements leads to the conclusion that the milk can was removed from Vauxhall Station on 12th March, 1908, taken to Richmond, and was brought back to Guy's. Furthermore, that it remained dormant for a year and was painted in Guy's colours to be taken to the final against London Hospital in 1910.

REVIEWS

SYNOPSIS OF ORAL PATHOLOGY

by S. N. Bhaskar. Harry Kimpton Ltd. *Price* 77*s*.

The best feature of this American text book is the initial 70-page classification of oral lesions, which gives the usual location, histology, prognosis, etc., for each particular item.

This is followed by an excellent short resumé of the general principles of oral pathology.

The remaining major portion of the book is devoted to a more detailed study of a wide range of conditions. Since this is an American book, some of the conditions mentioned, though interesting, are rather obscure for the British reader.

The book has a large number of illustrations, and the photographs are on the whole good. The photomicrographs are adequately labelled, although the pictures themselves are not always very clear. This is not a book which will displace the standard test book, but it might well be of interest to those aspiring to Honours, or to primary F.D.S.

TIM NEGUS.

METHOD OF ANATOMY.

Grant, 7th Edition. Ed. S. Livingstone, Ltd.

By regions, descriptive and deductive, runs the title, and this book, now in its seventh edition, is just that. The authors have made plain their conception that most of the tedium of anatomy can be made pleasurable by the use of one's reasoning powers to work out the majority of facts from a few basic principles. It is perhaps a pity that some embryology could not be included in this plan, but that would undoubtedly have increased the size of the book which even now runs at just over seven hundred pages.

The text is amply illustrated by numerous live drawings, some of which are very good, others by virtue of too much detail or shading are very bad. There are no colour illustrations, and this fact will damn the book in the eyes of those who can only warm to the subject when it is reprinted to artificial coloration.

In the copy I received, the pages, around 690, were in gross disarray, which made reading the chapter on the larynx like piecing together a jig-saw puzzle.

In reading the book for this review, I must confess to have derived much pleasure from resurrecting in my mind much anatomy which since 2nd MB I had thought was dead and buried. I think this book provides a stimulating and intelligible account of anatomy, and would thoroughly recommend it for the use of students.

MARTIN H. JOURDAN.

A BALANCED TEACHING HOSPITAL.

Published for Nuffield Provincial Hospitals Trust by Oxford University Press. Pp. 131. *Price* 40*s*.

A hospital with an integrated psyche?—the approach is straightforward and is gaining acceptance—integrate by balancing different hospital activities. Many of the ideas in this book clearly stem from a paper in the *Lancet* in 1958 by Professor Thomas McKeown, which was entitled " The Concept of a Balanced Hospital Community." In this paper, McKeown suggested that acute, chronic and mental hospitals should in future be built close together. The concept has been developed to include teaching and research functions. The book is a collection of medical, planning and architectural papers given at a symposium in Birmingham in 1963 organised by the Nuffield Provincial Hospitals Trust. McKeown's lucid prose graces the medical section, and the architectural and planning papers by Lord Llewyn Davis and Peter Cowan are also very readable. Though the symposium was about a specific project involving the Queen Elizabeth Hospital, Birmingham, local details in no way obscure the general argument.

A defect in the symposium was the omission of a sociological paper. What have studies in medical sociology to tell us about the likely interactions between staff, patients and community when hospitals with over 2,000 beds and their related out-patient services are brought together in what is virtually a medical village? How will the separate units be administered and controlled?

This is a depressing time to think about building new hospitals, but no doubt Britain will soon be forced to find some way of allocating enough money for this purpose. This book will undoubtedly improve the quality of whatever hospitals are finally built and will meanwhile interest those who study different ways of organising modern medical care.

PETER DRAPER.

FUNDAMENTALS OF ACID-BASE REGULATION,

2nd Edition. Professor James R. Robinson, M.D., Ph.D.(Cantab.), F.R.S.N.Z., F.R.A.C.P.

All sufferers from chemistry blindness should welcome this second edition of Professor Robinson's book on acid-base regulation. He has expanded the account on respiratory control in this edition to good effect, but has retained the major part of the first edition without change. This little book remains the clearest exposition of this difficult topic that is available to-day; its brevity is an object lesson to most textbook authors, for it is achieved without compromising on the adequacy of the explanation. Anyone about to sit examinations in chemistry would be well advised to outlay the cost of a few shillings to obtain this book.

M.F.D.

MODERN SURGERY FOR NURSES.

F. Wilson Harlow. Published by Heinemann at 37*s*. 6*d*.

This is a new edition of a well-known textbook for nurses. It has been revised and enlarged. It is a well produced book with many illustrations. The information is well set out and there are a great many lists which nurses find most helpful for study. The enormous range of material means that some sections are of necessity rather sketchy and there are certain omissions. Some material has been retained which could perhaps have been omitted to make way for descriptions of new techniques. For example, Judets arthroplasty might give way to Charnleys, peritoneal dialysis might well be included. However, this still remains a useful book for nurses.

B.B.W.

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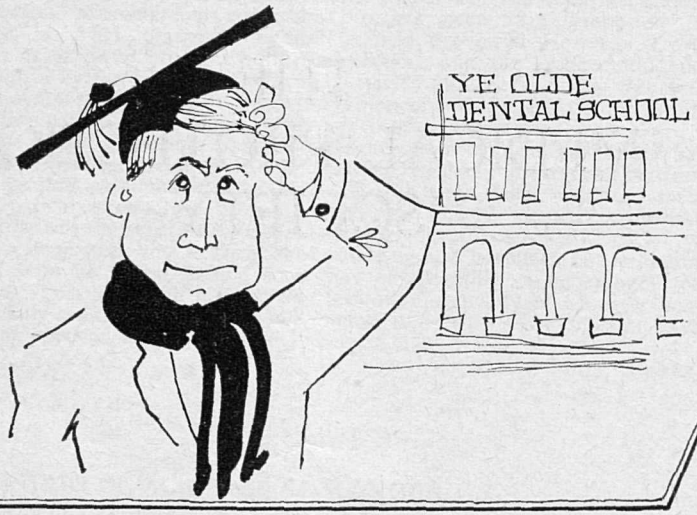

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SPORT

The past fortnight has been one of Cup Finals, and in reaching the top in so many sports, the Hospital may feel justly proud of its achievements this season. To date, Guy's has entered both Senior and Junior Rugby Finals, the Soccer Final, the Junior Hockey Final and the Golf Tournament Final. The golfers won handsomely, the "A" XV lost, and the 1st XV and 2nd XI drew. The Soccer Final takes place on Monday, March 21st, at the Westminster Hospital Ground, when Guy's meet The London. Support, as always, is welcomed, and coaches will be available. Earlier in the season, our athletes won the University Winter Field Events Meeting, and the Boat Club gained similar success in reaching five finals in the U.H. Winter Regatta, winning three.

The 1st XV must replay their final with St. Thomas's, for which our chances remain much as before. A draw after so much preparation inevitably leaves both combatants with an air of anti-climax, so that success on the subsequent encounter depends largely on regenerating maximum enthusiasm and determination. Let us hope in that our team receives the necessary support from the touchline, and that in our next issue we may report the safe arrival of two more cups to augment our collection.

DIARY

Mar. 19.—Rugby v. Gloucester. Home.
Hockey v. U.S., Portsmouth. Away.
Cross-Country v. Orion Harriers. Chingford.
,, 21.—Soccer. Final, Hospitals Cup. K.O. 2.30 p.m. Cobham.
,, 22.—Boxing v. London University (for Doris Penny Trophy). Pavy Gym.
,, 26.—Hockey v. Southgate II. Away.

REPORTS & RESULTS

RUGBY

Cup Final

GUY'S v. ST. THOMAS'S

At Richmond. Thursday, March 3rd, 1966

Result: drawn 0—0

This was a most exciting Cup Final, and the standard of play was far higher than suggested by some Press reports. That the match ended without score was naturally an anticlimax. That neither team was able to gain the final ascendancy over its opponents does not necessarily imply negative tactics.

After an encouraging season, based on the enthusiasm and able leadership of John Davies, Guy's has emerged with a powerful and well-balanced pack of forwards and considerable attacking power in the threequarters. Evidence of this is a tally of 60 points scored in the first three rounds of the competition, of which no less than 24 came from tries scored by the wings. Morale, therefore, before the match was high, and players and supporters alike journeyed to Richmond in keen anticipation of a Guy's win.

It was a perfect afternoon for rugby, and after the customary Rag had spent itself in the usual shower of plaster bombs, augmented liberally on this occasion by large quantities of Gentian Violet, Guy's kicked off in brilliant sunshine.

The first period of the game was spent largely by the two teams sizing each other up. Peace was jumping well in the line-outs, but too often possession was squandered by close kicking from the base of the scrum. No doubt this was partly a result of the effective spoiling tactics of the talented Thomas's back row.

However, the second quarter became much more open and exciting, with two good runs by Morgan and Ross. Guy's began to achieve territorial advantage, and this culminated in a beautifully executed dummy-scissors by the Guy's halves, the ball passing to Edgar who broke for the line with a fine burst of speed, but then agonisingly lost possession of the ball before he was able to ground it. An equal disappointment followed a few minutes later when, during a brisk shower of rain, Elliot, who otherwise played a faultless game at full-back, missed a relatively easy penalty.

Guy's, therefore, were unfortunate not to change ends at least three points up. However, St. Thomas's, having had this respite, started off to a storming second half, and it was soon their turn to be unlucky when Gosnold grounded the ball at the end of a fine attack after having put a foot in touch-in-goal. Nevertheless, they continued to press strongly and we soon began to see Cup rugby at its best, with play swinging from one end of the field to the other. This period was dominated by the St. Thomas's forwards, of whom Silk, Boyle and Steer were outstanding. One movement was particularly memorable in which they surged the full length of the field and only narrowly missed scoring as a result of some superb covering by Ross. However, Guy's defence held sound, and Swift in particular distinguished himself by the way in which he stood up to some very rough handling from around the loose scrums and line-outs.

Having contained these concerted pressures, Guy's began to mount their own attacks again, and Thorburn and Sharp proved seemingly tireless in their ability to remain with the ball. But the decisive score remained elusive, and when the whistle blew the final impression was one of honours equally shared. The game throughout had been played at relentless pace and the very evenness of the struggle had lent its own excitement. Credit should also be given to the relative infrequency of penalties, a reflection as much on the quality of play as on the impeccable refereeing by Mr. R. A. B. Crowe.

No doubt a lot of hard tactical thought will be expended before the next confrontation on March 17th. It would be foolish to prophesy,

but Guy's chances on this evidence must remain as high as before the match was played.

Team: D. R. Elliot; J. R. M. Ross, A. Edgar, M. Lindsey, I. J. Morgan; B. J. Rowlands, P. G. F. Swift; J. E. Davies (Capt.), G. B. Hey, R. Stansfield, P. K. Peace, A. J. Kingdon, H. C. Sharp, J. M. Cockburn, C. W. Thorburn.

T. ENGLISH

Junior Cup Final
GUY'S v. ST. BARTHOLOMEW'S

At Teddington. Wednesday, March 9th, 1966

Result: lost 6—15

In the Junior Cup Final, played at St. Mary's ground, Guy's were surprised by the fire of Bart's, on the field and touchline, gave away two early penalties and eventually lost by two tries to three tries and two penalty goals.

Bart's kicked off with the wind, but into the bright sun, and from the start harried a more constructive Guy's side into mistakes, holding the ball in the scrum to catch Guy's offside, and ignoring their backs.

Inside fifteen minutes Bart's were 6—0 up, converting the first two of their three penalty chances for scrum infringements; Morris, against the wind, was unable to reply in three attempts, and it took Guy's the rest of the half to recover. In the dying seconds they were within inches of scoring, showing some of the form of which they are capable.

The second period started with Guy's using their backs when possible, only to be stopped by some desperate tackling; and when Moore, combining well with the back of the line-out, was twice pulled down just short of the line, Guy's appeared to be getting on top.

But Bart's suddenly were on the Guy's line, and from a loose scrum their scrum-half dived under two players to score an unconverted try.

Guy's opened their scoring when, after some combined passing between the forwards, Hendrick broke from the tight scrum ten yards out, ran wide, and went over as he was tackled. The conversion failed.

The game switched ends immediately, and Bart's went further ahead when Guy's heeled from a scrum on their own line. The referee appeared to get entangled with the ball, which went loose, and the Bart's wing forward collected to score.

With time running out, Guy's scored the try of the match; the ball was moved out to the wing, Thomas, who had room to run for the first time in the match, and scored near the corner after beating three men on the outside.

Another opportunity was then wasted, when, with an overlap of two, the ball was run into the full back. Bart's cleared, kicked on down the field, picked the ball up, and when a change of direction left the Guy's defence outnumbered and wrong footed, scored near the posts. This conversion also failed, and the final whistle went with Bart's the winners.

Team: A. Morris; D. Lewis, S. Horsley, R. Beacham, G. Thomas; M. Cheesbrough, B. Moore; E. Neville, T. Gibson, A. Forbes, C. Neville, J. Stoneham, K. Brown, D. Hendrick (Capt.), D. Curzon.

J. SIEGLE

HOCKEY

Junior Cup Final
GUY'S v. ST. THOMAS'S

At H.O.P. Wednesday, March 9th, 1966

Result: drawn 0—0

Guy's could and should have won this match quite comfortably, but largely as a result of a distinct lack of co-ordinated effort, they managed to squander their scoring chances and were lucky not to have at least one goal scored against them.

The first half was uninspiring, with Thomas's mounting a number of attacks which were successfully, though at times fortuitously, beaten off by the Guy's defence. The Guy's forwards seemed unable to penetrate, and many of their passes found only the opposition centre-half. Gill, on the right-wing, managed to send across a number of potentially useful centres, but nothing was made of them.

The second half began where the first left off, with Guy's moving slowly, passing badly, and with the defence unable to clear effectively. Midway through the half Guy's suddenly clicked and for about five minutes looked quite dangerous. The forwards combined better, and the halves were passing intelligently. The pressure was kept up and Guy's were awarded a penalty flick when a Thomas's defender suddenly picked up the ball in his own goal-mouth. Although the shot beat the goal-keeper, the goal was not allowed as the striker had taken more than one pace. Soon Thomas's were back on the attack, and one move ended when Guy's scrambled the ball away after a shot had hit the post. Thomas's also had two short corners, but failed to score from either.

Extra-time brought no change in the Guy's attitude to the game. They were just rescued from defeat by an excellent save by White—one of the few players on the Guy's side to rise above the generally low standard. On the whole, a very poor game, although on the day's play the result was probably a fair one. One can only hope that by next year the team will find sufficient determination and "go" to win the Cup outright—sharing it is not good enough.

Team: N. White; J. Saloman, R. Jenkins; S. Worthington (Capt.), N. Turfitt, P. Rushmer; J. Gill, A. Godfrey, A. Brooks, N. Dodd, M. Tan.

S. WORTHINGTON

THE PAST v. THE PRESENT

At H.O.P. Sunday, March 6th, 1966

Result: Present won 1—0

This was the first such fixture, and was held at H.O.P., on Sunday, 6th March; the bully-off being at approximately 2.45 p.m. Most players and spectators had met at about 1.00 p.m. in the Miller to get "acquainted", and then drove to the ground for a few more beers. There to meet them were the past players, with families who were already enjoying the sunny afternoon.

The Past had quite a strong side, with J. A. Dyde, a Cambridge Blue, as captain. In fact, they had twelve people to select from, and it was decided that a substitute should play after half-time, and A. Hopkins gave way to J. Sedgwick at centre-forward.

The Present had intended to have a big score in their favour, but this was not to be, and at the end of the game they were very lucky to have won 1—0. This was due to a good half-back line, with Roger Lallemande playing a large part, and a strong forward-line in which R. Strickland, J. Sedgwick and Paul Bennett were always dangerous. The wings were not used enough, which allowed the "Present" defence to concentrate on the inside trio.

For the Present little can be said other than we should have scored a couple more goals in the first half before the "Past" had settled down and had got used to playing together. It was not one of the Present's better games, although it was most enjoyable and quite exciting at times, especially in the last twenty minutes. It was during this time that the Past attacked very strongly and during a mêlée around the Guy's Present goal a penalty flick was given and R. Strickland stepped forward to take it. It was well saved by S. Rear, although in doing so he

seemed to push the ball forward with his hand. However, it passed the scrutiny of the umpires and the result was a fairly good record of the play. The enjoyment of the game was to a large extent due to the excellent umpiring of K. Lochhead and C. Hunter-Craig.

Notable amongst the spectators was Dr. G. Scott and family, the Vice-President. Professor Butterfield was unable to be with us as he was overseas at the time.

While the players were bathing afterwards, the children had a small tea-party, replenishing their glasses from their own "jug" which properly contained only orange squash.

It was a good social evening, and an hour or two later, after a couple of notable bar games, a party of about 20 players and spectators went for a curry before departing for home.

Past Team: R. A. Pearson; J. A. Dyde (Capt.), D. Loader; J. Davies, R. Lallemand, P. J. Tombleso; P. Liddiard, P. Bennett, A. Hopkins/J. Sedgwick, R. E. Strickland, M. O. Rake.

The great success of this fixture ensured that it will be a permanent event, held on the first Sunday in March.

C. A. BROOKS

ASSOCIATION FOOTBALL

Hospitals' Cup Semi-final

GUY'S v. MIDDLESEX HOSPITAL

Saturday, March 5th, 1966

Result: won 2—1

By their victory over Middlesex Hospital the Guy's soccer team reached the final of the Hospitals' Soccer Cup and this gave further grounds for the exciting hope that Guy's can achieve the notable double of winning both the Rugger and Soccer Cups in the same season. How notable this would be is borne out by the fact that when the Soccer Cup was won in 1964 we did not win the Rugby, and the previous success at Soccer had been as far back as 1947.

Only two members of the victorious team of 1964 remain with the club. D. Lindridge, L. Carver, R. Lovell and D. Ward are all in their first year at the Hospital, and their fine performance on this occasion augurs very well for the future of the Club.

The game started with a period of sustained pressure on the Guy's defence, during which the efficiency and calmness of the unit, superbly marshalled by I. Nash, who surely merits the "man of the match" tag, belied their newness to such tense, demanding football.

Gradually, with wing-halves S. Poole and R. Lovell asserting themselves in mid-field and J. Powell-Jackson doing his usual Trojan act, the tide was turned and the Middlesex goal became the scene of some feverish activity on the part of both sides. Guy's were distinctly unlucky when the referee disallowed a seemingly good goal when D. Jacobs found the back of the net following a free kick from the edge of the penalty area.

At the other end D. Lindridge dealt confidently with everything coming his way, being especially decisive in cutting out high balls into the goal area. However, he could do little to prevent the Middlesex taking the lead with a simple goal following a slip up in the Guy's defence. Things began to look ominous, but Guy's, much encouraged by the presence of Professor Haslewood and family, plus an equal number of other faithful supporters, were soon back on top. Chances were created but marksmanship was lacking, and at half-time the score remained 0—1.

The game continued to be exacting and hard after the interval with Guy's having slightly the better of things but unable to capitalise on the opportunities created. When a shot from J. Powell-Jackson struck a post and bounced tantalisingly along the goal line only to be cleared, one could sense the spread of the feeling that this just was not our day. A shot from D. Ward crashed against the underside of the bar, bounced somewhere near the goal-line, and was eventually cleared to the referee's satisfaction.

A just penalty award gave Guy's their supreme opportunity to come back on level terms. J. Powell-Jackson thudded the ball into the net only inches inside the post so that Yashin, not to mention the lesser mortal Middlesex custodian, could have added nothing more to the proceedings but the return of the ball to the field of play.

Despite having been in arrears for about an hour of the game Guy's had shown no air of desperation in their play. Now that the pace began to slacken as both sides tired their man to man football gave them domination of the game. The winning goal came from a short goal-kick by J. Powell-Jackson, the ball proceeding via Elias, Anto and Ward to Poole, who finding hitherto unknown reserves of energy sprinted through the middle and placed the ball out of the reach of the advancing Middlesex 'keeper.

The game had been lost and won, and all subsequent approaches to goal scoring were by Guy's forwards. Their continued failure to obtain a scoreline reflecting their share of the attacking, is something that must be remedied if the London are to be vanquished in the Final on March 21st.

Team: D. Lindridge; R. Davey, L. Carver; S. Poole, I. Nash, R. Lovell; M. Anto, E. Elias (Capt.), D. Ward, J. Powell-Jackson, D. Jacobs.

ELWYN ELIAS

GOLF

Hospitals' Cup Final

Result: Guy's 4, St. Bartholomew's 1.

D. Adams bt R. Atkinson, 3/2.
B. Bevan-Jones lost to J. Saddler, 1 hole.
P. Ellis bt M. Bowen, 5/4
M. Brummitt bt R. Begent, 7/6.
A. Philips bt C. Booth, 5/4.

For the third year running Guy's have won the Hospitals' Cup Final. On a fine spring day, at the Berkshire Golf Club, St. Bartholomew's were beaten by four matches to one.

When the ten players assembled on the first tee it was clear from their tanned skins that few of them had spent much of the last month in the hospital. But a glance at their opening shots made it equally clear that little of this time had been spent on the golf course.

D. Adams was perhaps the exception. With seemingly effortless ease he disposed of his opponent by 3 and 2. He also managed to persuade the only female spectator to watch the whole of his match.

B. Bevan-Jones was never his usual self and found the Berkshire jungle very trying. In such circumstances his loss on the last green was evidence of a determined performance.

P. Ellis, known as The Farmer, on account of his agricultural swing, paid fewer visits to the cabbage than is his wont. As a result he won by 5 and 4.

M. Brummitt was eight up after eight holes and level 4's. This was brilliant and ruthless golf. He played only slightly less well over the next four holes and won by 7 and 6.

A. Philips has yet to lose a game for the hospital. He left the fairway only once during the match and thus demoralised a very much wilder opponent.

All five players are again available this year, and so the club can look forward to an excellent chance of retaining the cup for a fourth successive year.

P. D. M. ELLIS

HOSPITAL INFORMATION

PASS LIST

UNIVERSITY OF CAMBRIDGE

M.Ch.

J. N. Gibson — A. B. Richards
M. N. Morgan

UNIVERSITY OF LONDON

M.D.

B. M. N. Pitt

Ph.D.

J. Wilson — R. S. Mellick

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PERSONAL

East Grinstead, Sussex. Two weeks' free board and lodging end of March, while relieving staff home Warden. Very light duties only. Write to Matron, Queen Victoria Hospital, East Grinstead.

S.R.N. required for Private Dental Surgery, to commence 25th April. No National Health patients. Some typing necessary. Apply by letter or telephone, 91, Hamilton Terrace, N.W.8. (Cun. 2244).

CHANGES OF ADDRESS

Miss J. Clemmey, to P.O. Box 1,000, Nassau, New Providence, Island, Bahamas.

Major R. C. Francis, M.B., M.R.C.O.G., R.A.M.C., The Maternity Unit, British Military Hospital, Hanover, B.F.P.O.33.

M. Gillon, Esq., B.D.S., L.D.S., R.C.S., to 132, Thwaite Street, Cottingham, Haltenprice, E. Yorkshire.

D. B. Waters, Esq., to 17, Grove Terrace, Teddington, Middlesex.

Dr. K. Wilderspin, M.B., B.S., D.M.R.D., to X-ray Dept., Henderson General Hospital, Hamilton, Ontario, Canada.

BIRTHS

BURSTON.—On December 16th, at Farnborough Hospital, to Rosalie and Robert, a son, Antony John Clement, a brother for Elizabeth Rose.

DAVIES.—On 23rd February, 1966, to Avril (née Chopping, S.R.N.), and Dr. Geoffrey Davies, of 45, Whitehall Road, Bromley, Kent, a son, William John, a brother for Robin and Penelope.

O'SULLIVAN.—On 26th October, 1965, at the London Clinic, to Nigel and Margaret O'Sullivan (née Gates, S.R.N., O.N.C.) a son, Nigel Martin Dominic, a brother for Anna.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

MARRIAGE

GRILLI—GRIFFITH-EVANS.—On March 5th, 1966, at St Mary's Church, Cadogan Street, Chelsea, Robert Grilli to Arfona Griffith-Evans, S.R.N., S.C.M.

DEATHS

BLACKMAN.—Daphne, St. John Blackman, S.R.N., S.C.M., died on 1st February, 1966, aged 51 years, following a prolonged illness. Miss Blackman trained in the Guy's Hospital School of Nursing, 1933-38. She was appointed as a Sister at Guy's 1938-39 and became an Assistant Health Visitor in Salomon's Centre in June, 1945.

GRATION.— Marian Gration, S.R.N., S.C.M., died on 1st February, 1966, aged 87 years. Miss Gration completed her training in the Guy's Hospital School of Nursing in November, 1905. She was appointed as a Sister from 1930-1939.

WORTHINGTON.—On February 25th, 1966, Charles L. Worthington, M.B., B.S., M.R.C.S., L.R.C.P., of Fontmell Magua, Dorset, dearly loved husband of Audrey, and father of Mary and Sidney.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2026

PASSIM

Thomas Hodgkin

Monday, the 4th of April, is the centenary of the death of Thomas Hodgkin. All of us now connected with Guy's derive some reflected glory from Hodgkin. He and other great men like him, have made the hospital a place that everyone can be proud to be associated with and it is fitting that we should honour him.

It is perhaps sad that Hodgkin's international fame should rest only upon the dire malignant disease that bears his eponym. For apart from being a brilliant pathologist, he was also a leading humanitarian and educationist whose ideas have had and are still having a profound effect right up to the present day. It was Hodgkin who, after returning from the Continent, where he had spent some time working under Laënnec, introduced the stethoscope to Guy's and possibly hence to the whole of England. It was he also who brought back the suggestion that we should adopt the methods of bedside teaching with the student reading out the history to the consultant in charge. Appointed as first curator to the Gordon Museum, he became foremost in championing the application of those scientific methods to medicine that have within such a short span of time transformed the doctor from a helpless bystander into an active healer.

One's respect for him as a man does not stop there, however, for in addition to his scientific prowess he was a determined and outspoken philanthropist. In an age where liberal thought was struggling against a hardened social conservatism and in a country that was obsessed with a crude, domineering patriotism, Hodgkin was a declared internationalist who actively attacked racialism and social injustice. The amusing episode when he rode into the forecourt of Guy's with a Red Indian in full head-dress, exemplified the depth of his convictions but it may well have been this that was used as a pretext by the more prejudiced Governors of the Hospital when they so foolishly and ungratefully refused him a place on the Consultant Staff.

Hodgkin's unopposed resignation following this refusal was a shameful tragedy for Guy's. He was thirty-nine and at the height of his career and had served the hospital for 12 years. Sir Samuel Wilks,

who later did so much to repair the wrong, writing in the *Gazette* of 1908, said, "This resignation was an immense disaster to the cause of scientific medicine. Guy's Hospital lost one of its greatest ornaments, and the whole profession in England lost one who was destined to shed lustre on its ranks."

Writing today we can say that as long as civilisation exists, Thomas Hodgkin will not be forgotten. His ideas and his ideals will live on and his intellectual honesty and moral courage will remain a lasting inspiration and example to each successive generation of Guy's men.

Without Planning

The General Election has delayed the passage of several important bills and reports through Parliament and has given us time to think. In this interval the B.M.J. has hurriedly called for medical opinion on the Abortion Law before the profession, without having expressed its views, is overtaken by the legislators. The silence of the medical profession on this important issue is an evasion of a social responsibility which it must bear, and it is commendable that the B.M.J. calls for opinion even at this late stage.

The new Government will have to face the impending crisis in the National Health Service. The General Practitioner, the most important person in the Health Service, is probably the worst hit by the paucity of central medical planning, and the solution to their problem will not solely be found in remuneration schemes. The difficulties of General Practice are perpetuated to some extent by the short-sightedness of educational planning. The majority of medical students will become general practitioners, yet they are rigidly trained for hospital service. The medical student sees only that part of the history of the disease which takes place in the formally controlled environment of a hospital and the environmental issues from which the patient comes and later returns are rarely his concern. Their influence on the course of the disease are unknown to him and he is given little formal teaching or experience of this while an undergraduate.

There are very few definite plans for the Health Service of the future and medical education is already becoming unsuited to the demands of even the present system.

> "*It is not enough for us to do what we can do; the patient and his environment and external conditions have to contribute to achieve the cure.*"—Hippocrates.

Dr. Hugh Herbert, who qualified at Guy's in 1946, has been appointed Sheriff of the County of Cardigan. Dr. Herbert is in general practice in Aberayran.

GUY'S DIARY

APRIL

Exhibition:			Obstructive Jaundice.
4th	M.	1.00	Clinical Lecture, Dr. MANN. "Haematemasis and Malaena".
5th	Tu.	1.00	Clinical Lecture. Mr. SCHURR.
12th	Tu.	1.00	Clinical Lecture. Prof. JOHN F. NAJARIAN, M.D., Assoc. Prof. of Surgery, Univ. of California, San Francisco.
21st	Th.	5.00	Neurosurgical Round: conducted by Mr. SCHURR.
23rd	S.	10.00	Clinico-Pathological Conference in the Clinical Theatre.

DAPHNE ST. JOHN BLACKMAN

DAPHNE ST. JOHN BLACKMAN died of multiple sclerosis in Guy's New Cross Hospital on 1st February, 1966. Her career was a remarkable one.

She trained as a Nurse at Guy's from 1933 to 1938. She was an excellent nurse and was appointed a Ward Sister. At the outbreak of war she joined Queen Alexandra's Imperial Military Nursing Service, 1939-1941. While nursing the wounded from Dunkirk, she caught "a virulent fever". After sick leave and return to work, some symptoms of multiple sclerosis appeared; these rapidly developed and she became paralysed and almost blind. Invalided out of the Army, she returned to her home in Norfolk to be nursed. A couple of years later she began to make a wonderful recovery. It had been her keen desire, after the war, to become a Health Visitor. As her health improved, Guy's decided, to her great satisfaction, to accept her for training in the Salomon's Infant Welfare Centre, and after she had passed the qualifying examinations, she was appointed there as a full time Health Visitor. As always, she put her whole heart into her work and carried on successfully, much loved by her Boro' mothers until 1953, when her increasing disability became too great a handicap. She returned to her home and for thirteen years was cared for there by her devoted mother, slowly declining in health, fully understanding how her disease must progress, but never giving up her interest in country things and the village people round her, and in the developments at Guy's. Every winter, one of my most beautiful Christmas cards came from her with a letter full of cheer, telling me of all her interests and invalid activities, written at first by herself and later by her mother.

When, last autumn, her helpless condition called for hospital care, she sent me a message saying how good it was to be back once more in a unit of Guy's, surrounded by the Guy's spirit, even if she could not be nursed at Guy's itself.

If, in these long, last thirteen years, she has even—out of the depths—felt despair, her unconquerable soul surmounted it.

> "One who never turned his back but marked breast forward,
> Never doubted clouds would break,
> Never dreamed, though right were worsted, wrong would triumph,
> Hold we fall to rise, are baffled to fight better,
> Sleep to wake."

She was of that company. God rest her.

E.P.M.

ASPECTS OF OCCUPATIONAL THERAPY IN PSYCHIATRY

by

V-M Wichman, S.R.O.T.

At a recent sale of work in an Occupational Therapy Department one long-established member of hospital staff took a quick glance at the various stalls, uttered in disbelief: "No soft toys!"—and left. This sadly reflected the popular misconception that Occupational Therapy is: soft toys, baskets and the odd bit of mis-shaped pottery. These oddments may indeed be found scattered round a department, but the emphasis of this service today is much more on realistic rehabilitation than on pretty-pretty handicrafts.

Occupational Therapy, though as a profession relatively new (30 years), has been known since the beginning of medicine. About 2000 B.C., the Egyptians dedicated temples to melancholias; all the patients' time was taken up with "some pleasurable occupation". Since the middle ages, activities prescribed for the disabled have been divided between recreational and those related to work and daily living. From the beginning of this century, however, there was a tendency to regard work—or realistic activities for patients, particularly psychiatric, as exploitation. So the members of the budding, but still nameless profession, turned to arts, crafts and recreational activities in order to occupy patients; and these diversional activities gradually became known as "Occupational Therapy"—creating an image that has proved extremely hard to obliterate.

Over the last 20-25 years there has been a steadily increasing trend towards realistic rehabilitation of physical, as well as psychiatric patients. The increased need for rehabilitation of physically handicapped during and after World War II, probably led to revision of ideas in the physical as well as the psychiatric field. However, the most important factor was the introduction of new methods of physical treatment (E.C.T. 1937) and new drugs (tranquillizers 1955). These opened up a tremendous scope for retraining and resettlement of those patients who before would have had to spend the rest of their lives in a hospital or institution. It is now generally accepted that treatment and rehabilitation go hand in hand, and begin with the patient's admittance to hospital. The lines along which rehabilitation is carried out, and the roles of the various members of the treatment team, depend to a large extent on the orientation of the medical officer in charge.

In Occupational Therapy applied to psychiatric conditions one distinguishes between two main groups of patients:—

(I) Chronic.
(II) Acute psychotic and neurotic.

(I) The ultimate aim of rehabilitation is to resettle the patient outside the hospital as an independent, responsible, working member of the community. The work-habit and special skills may have been lost during long periods of hospitalization. In addition, chronic schizophrenic patients (who fill 60 per cent of all mental hospital beds) are handicapped by flattening of affect, lack of drive, incentive and interest. So not only retraining of work-habits, but also resocialization is necessary.

When the patient first is referred to Occupational Therapy, a primary assessment is carried out covering :—

Concentration.
Memory.
Learning ability.
Manual dexterity.
Initiative.
Ability to mix and attitude to group.

This may be done through the medium of crafts, particularly chosen for their assessment value, i.e., whether they show up the patient's ability—or lack of same—in points as those listed above.

Sometimes a patient is thought likely to benefit from artistic activities, such as painting, pottery, etc. These may serve as a means of communication for the very withdrawn or regressed patient, or may provide an emotional outlet. Other patients may simply benefit from the relaxed and permissive atmosphere which is the essential background for these activities.

If there is any likelihood of the patient returning to his former employment, a graduated programme will be organized, through which he can regain lost work-habits and skills. Other patients may develop their abilities through work in the carpentry workshop, the hospital grounds, the utility departments, or on the hospital farm. All work is graded to suit the patient's immediate ability and needs.

But the majority of long-term patients need complete retraining of their work-habits; and for this purpose industrial work is well suited, when chosen to meet the patient's specific requirements. Contracts may be provided by local industry and may consist of anything from dismantling gasmeters to light assembly work and painting of toys. Each contract is "broken down" in various stages, and the patient, when first starting, will get a job that is simple and repetitive, graduating in complexity as he improves in:—

concentration,
speed,
accuracy,
consistency,
reliability,
punctuality,
initiative.

The final stages of industrial rehabilitation are made as realistic as is possible within a sheltered environment. Patients are paid for their work, which, of course, adds incentive; in some hospitals according to effort, in others on a piece-rate basis. Although some patients may be resettled in a job directly from hospital, many may have to attend an Industrial Rehabilitation Unit for further assessment and training at a level which the hospital cannot offer. Some may go to Government Training Centres for specific vocational training.

Patients rehabilitated through industrial therapy are not necessarily resettled in this type of work. Slowness is a major handicap for chronic patients, particularly schizophrenics, and many are unable to overcome this. If suitable employment cannot be found, these patients may attend sheltered workshops or rehabilitation centres as day-patients. Whatever the conditions of resettlement, it is important that the patient should feel he is a contributing member of the community. Unemployment, or inactivity during long periods, have serious effects upon mental health, and may cause relapse and rehospitalization.

Resocialization runs parallel to rehabilitation and covers a wide range of activities; particularly those that naturally assist rapport and relationships with fellow patients, are of great value. These include sports, musical groups, drama and group-projects such as marmalade making, production of Christmas decorations, painting of murals, etc. etc. Patients are, due to flattened affect, lack of drive and initiative, apt to withdraw from reality and need constant encouragement to join activities and outings. The patient is also encouraged to spend money earned through work, on something he finds particularly desirable, be it a visit to the cinema, or a shopping expedition to a local town. In this way the patient learns to link work with money, and money with pleasure, thus adding interest and incentive to the work pattern and teaching him, to some degree, the value of money.

Chronic patients are particularly apt to form habits—good or bad; and once formed they are hard to reverse.

As a final preparation for their discharge from hospital, female patients may be selected to go and live in a "flat"; a self-contained unit within the hospital, which usually accommodates 6-10 patients. Although under supervision of the Occupational Therapist, the patients make their own budget, shop, cook their meals, do their own washing and ironing, and organize their social activities, just as they would outside the hospital. This gradual weaning from the sheltered environment gives the patient an opportunity to gain confidence in her independence, and also serves as a final assessment before resettlement in the outside community.

(II) Occupational Therapy in the rehabilitation of acute psychotic and neurotic patients is usually directed towards a specific aim, rather than overall rehabilitation; but also here a primary assessment is essential. This covers as in chronic patients: concentration, memory, ability to learn, manual dexterity, initiative, ability to mix and attitude to group, plus imagination and motivation, and may be done through

the medium of crafts, realistic and group activities. The type of activity chosen depends on the patient's diagnosis and the aim of treatment, i.e., assessment and observation, providing emotional outlet, and reducing anxiety, gaining confidence, conditioning, rehabilitation, resocialization, etc. etc. A work or group situation will often show up symptoms that may pass unnoticed under other conditions, and any observations of deviation may be of importance in the future management of the patient.

Crafts such as basketry are mainly used in primary assessment, as they are easily up- or down-graded in complexity, but may also be used in the treatment of very retarded patients or as a means of retarding deterioration in dementing patients.

Many patients are in need of intensive rehabilitation as, for example, after treatment such as neuro-surgery, successful treatment of conversion hysteria or in deconditioning of phobic anxiety states. The graded programme is then planned on as realistic a basis as possible, and related to work and daily activities such as cookery, typing and shorthand, dressmaking, gardening, wood- and metal-work, printing, etc. In some hospitals the Occupational Therapist supervises deconditioning regimes for phobic anxiety states, and also teaches relaxation; but opinions are divided, and some doctors like to supervise those programmes personally.

Creative activities, such as art and pottery, take a prominent position in the treatment of acute psychotic and neurotic patients, and are of high therapeutic value. They are mainly used for patients who need a creative or emotional outlet, whether initiated voluntarily, or directed (as, for example, for patients with hysterical contractions of fingers and hands.) Painting leaves the widest scope for free expression; opinions are divided as to whether patients should be taught painting techniques; many feel that teaching is inhibiting to free expression and therefore reduces the therapeutic value. An acutely disturbed patient will often paint with great energy and spontaneity and become more conventional and restrained as his mental state improves and his outlook becomes more realistic.

Art may be used as an aid to diagnosis; however, many doctors are acutely aware of the possibility of projection of ones' own fantasies into patients' paintings. For interpretive purposes not only a comprehensive knowledge of psychiatry and the patient concerned is necessary, but also familiarity with painting techniques and the subject as a whole.

Clay is another valuable medium in the treatment of psychiatric patients; it is satisfying to work with, as every touch leaves a mark. Severely obsessional patients who feel unable to tolerate dirt, may be gradually deconditioned through working with clay. The preparation—or wedging of clay, may provide an outlet for the aggressive patient, as it requires a great deal of energy. Clay modelling provides ample scope for creativity, as does "thrown" pottery; the simple

technique of slab or coiled pottery may give the anxious or regressed patient a great sense of achievement and helps to improve concentration. The two latter techniques may also be used in the assessment of patients with suspected dementia, as these find it particularly difficult to learn new skills, however simple. For the patient who requires a creative activity with a controlled and disciplined medium, activities like mosaic work and lino-cutting and printing are ideal.

Group activities play a very important part in resocialization, and may be used as a means of assessment of the patient's ability to mix, attitude to the group and initiative. These activities also serve to condition the patient to a normal social life, from which he may have withdrawn completely owing to his illness. Patients are encouraged to take an active part in the activities, and if possible help to run them; this gives the patient a sense of responsibility and helps him to gain confidence. Activities range from group-projects such as producing the hospital magazine, to sports, dances, party-games, debates, quizzes, music (active and passive), drama and outings to concerts, theatres and places of interest. Drama is a group activity which can be particularly valuable to the individual. While the chronic patient may derive the greatest benefit from taking part in a play, which provides a natural framework for communication and rapport with fellow-players, the neurotic patient may benefit more from improvisation, charades and free movement to music through which he will be able to act out pent-up emotions and situations of stress. This may also assist in assessment and diagnosis.

There are many other aspects of Occupational Therapy, all being specialized and adjusted to suit the requirements of the particular group of patients under rehabilitation.

The aims of Occupational Therapy are not directed towards making institutional life bearable for the patient, but towards realistic reablement and the patient's early return to the community as an active member.

There is no doubt that the methods of rehabilitation will change further in years to come; for example, will the possibilities for using "programmed learning" in Occupational Therapy have to be explored? But whichever methods are employed, close liaison between members of the treatment team is essential to ensure efficient resettlement.

LITERATURE RETRIEVAL

by

William Hill

Wills Librarian

J. S. Billings wrote in 1879: "It is as useless to advise a man not to start a new journal as it is to advise him not to commit suicide." This was written against a background of the 860 medical journals then currently published.

At the present time the number of bio-medical journals is thought to be about 5,500, although the number depends on the definition of bio-medical journal. The National Library of Medicine in Washington considers that, using the broadest conception of bio-medical journal, the total number approaches 14,000, although this includes such publications as annual reports, etc.

The number of current scientific and medical journals to be taken by the National Lending Library in Yorkshire is 26,000, and it is considered that this is the total published. Again opinions differ, and some authorities would give a total figure of over 30,000 as a more accurate figure.

How many papers this represents during the course of a year is impossible to say, but at a conservative estimate there must be at least 500,000 papers of medical interest appearing during the year. The problem facing everyone concerned is how this mass of information can be made available to readers. Various schemes have been devised which involve the abolition of the journal as we now know it, and the substitution of a central clearing house of information which would supply copies of papers to interested parties. Such a scheme is well into the future, and for the time being it is necessary to face the situation as we find it.

It is no new problem. In fact, it has been discussed over the past 200 years. Von Haller, in the eighteenth century, compiled vast bibliographies of books and papers known to him, and his industry was phenomenal, but even so the task was clearly beyond the efforts of one man. Over one hundred years ago the situation was causing concern, and the first abstracting journals came into being. In 1879, the *Surgeon General's Catalogue* started its career, and continued to appear until the mid-fifties, when it became painfully obvious that the task was impossible. Parallel to this was the *Index Medicus* and its successors, which continued until the late fifties. The last volume was already several years out of date, and this delay in publication

was the obvious drawback when conventional methods of indexing were employed. Consequently, recent developments have been towards computer indexing. The most famous example is the new *Index Medicus* and its associated system MEDLARS (*M*edical *L*iterature *A*nalysis and *R*etrieval *S*ystem) being developed at the National Library of Medicine.

This system is based on a Honeywell-800 digital computer. 4,000 periodicals are analysed by editors and their contents indexed. An entry is made for each author, the title (and a translation if necessary), the journal reference and up to ten subject entries to cover the scope of the paper. The subject terms used are taken from an authority list published annually. This information is fed into the computer by paper tape and converted to magnetic tape for storage. The output is another magnetic tape which is used to operate a composing machine able to produce masters for printing. From these the monthly issues of *Index Medicus* are produced. For this only the authors and three subject entries are used. This means that a paper will appear under three possible subjects. The rest of the terms are, however, stored in the computer's memory. This computer became operational in 1963 and is ready for research. The questions which can be asked are derived from the subject heading lists and other criteria—authors, journals, language, etc., can be used to narrow the search. For example, it will be possible to pose such questions as "All references to multiple myeloma, but if more than fifty only those in English need be supplied, and if these in turn amount to over fifty (or whatever number is chosen) those published within the last year." To scan a year's literature will take about 30 minutes, and the machine should be able to handle about ninety searches a day.

Although this scheme was devised and is operated in Washington, an experimental project is about to start in England. The National Lending Library, in conjunction with the Computer Laboratory of the University of Newcastle, is being supplied with copies of the tapes used, and a search service will shortly be available in this country.

This may sound the answer to the problem, but the system has its limitations. A machine search differs from a manual one mainly in that the computer has to be programmed in advance with agreed subject terms and these terms must be followed at all times. Secondly, as the index is a co-ordinate one, a combination of terms should be used. For example, papers which fall into the category of "The treatment of X with A and B" would involve the use of terms for X, A and B. Failure to do this would mean either irrelevant papers being supplied or, more serious, important ones being missed. The cost of a search is roughly equal to several hours' work by a trained librarian, and it is important that these limitations be known. It is hoped that a member of the library staff will attend a training course in the near future, and this will enable the Wills Library to act as a centre within the hospital able to advise readers on what is possible and to carry out the initial subject term selection. The next few years

should enable us to see if the computer can replace manual searching of the literature.

Instead of a computer, other forms of data processing could be envisaged. Unfortunately, the bulk of the entries seem to rule out this form of storage. Punched cards may well be the answer for small scale problems where detailed information is desirable, but the number of cards required for a year's output of medical papers would tax the storage capacity of any unit, apart from the problem of feeding the machine for each search. Magnetic tape would seem to be the only solution.

Hitherto we have been discussing indexes. There are two other types of publication which are designed for literature retrieval. These are the contents lists and abstracting journals. The contents list type of publication is illustrated by *Current Contents* published weekly by the Institute of Scientific Information. This reproduces photographically the contents pages of a large number of journals. These are printed from the plates, collated as a journal and posted out. The time factor is all-important. The plates are prepared during the first part of the week, printed and made up by Friday and dispatched to New York. From here they are sent by K.L.M. night flight to Amsterdam, arriving on Saturday morning. From Amsterdam they are posted to all parts of Europe. In theory, all copies should be delivered on Monday morning, but with postal delays the Wills Library copy does not arrive until Wednesday. It is regrettable that after the efforts made to facilitate production in the United States postal delays on this side of the Atlantic should hold up delivery.

The advantages of this type of publication is the rapid dissemination of knowledge but, as it is a contents page list, any search for a specific subject is impossible without reading each page in turn. As a means of skimming the surface of current journals it has no equal, and for that reason alone must be considered a very valuable source of information. A more local example of this type of publication is the duplicated list issued by the Postgraduate Medical School.

An offshoot of *Current Contents* is the *Citation Index*. This is a new development in information science. Briefly it is a method of finding out what work has been carried out either in the past or present relating to a specific paper. For example, a research worker reads a paper published in 1960. He wonders what work based on this paper has appeared since. The Citation Index will supply the references to any papers published subsequently which quoted the original article. It is possible to use the index to go backwards as well as using the original article as a base. The publishers claim that this approach cuts across disciplinary lines and pulls together what seems to be unrelated material. They quote as an example a relationship between a paper in *J. Dairy Science* for 1959, and a paper by Einstein in *Ann. Physik.* for 1906. The same early paper was also quoted in papers which on the face of it appear to be incongruous. The cost of this index is high, and at the moment beyond the resources of the Wills Library. The same institute operates a system whereby subscribers receive weekly reports of papers of interest.

Abstracts have been in use for over a hundred years, and there are a large number of abstracting journals and journals containing abstracts. The drawback of these is the time delay in publication. Usually the most recent papers cited are six months old. Indexes to abstracts are often delayed and in order to speed up this process, the KWIC (Key-Word-In-Context) system has been introduced. This uses a computer to produce indexes.

The basic words of the title of any given article are selected and fed into the computer which retrieves and arranges them in alphabetical order. This is printed out with the key words in the centre and modifying and explanatory words on either side of it. This arrangement is, at first sight, confusing, but users become accustomed to it. *Chemical Titles* appears in this form, but the publication more generally used by biomedical research workers is *Biological Abstracts* and its companion works. The subject section is published as BASIC (Biological Abstracts Subject In Context). This is a complete alphabetical list of all key words and reference numbers to the corresponding issue of Biological Abstracts. In *Biological Abstracts* the abstracts are arranged in classified order. In this also are the index of authors, a biosystematic index of taxonomic categories and a CROSS (Computer-Rearrangement Of Subjects Specialities) index. The use of this index is, to quote the official description, "for the determination of those abstracts which have interests common to two or more categories in *Biological Abstracts*". Although this index appears rapidly, the abstracts to which it refers are still six months old or more.

The Wills Library has for a year or so been considering offering a retrieval service to its readers. Various pilot schemes have been tried and tested, and the scheme now coming into use is the result of these experiments. It is obvious that it cannot provide services equal to any of those described, but we feel that a comparatively simple scheme is possible and potentially useful.

At the moment a large proportion of the journals received in the library are scanned and the contents indexed on slips. These slips are filed under subject headings based on the *Index Medicus* so that users can move from one to the other without change of nomenclature. This does mean that American spelling is used in the Wills Library index. The system is housed in a cabinet alongside the other bibliographical journals at the end of the library. Each subject has a guide card, and behind each card are the reference slips on the subject. Each reference comprises the title of the paper, followed by the title of the journal in the briefest possible form, together with date, volume and page. For example:—

The behaviour of hypertension in pregnancy.
MJA-65-2-1021.

indicates that this paper can be found in the *Medical Journal of Australia*, 1965, Volume 2, page 1021. A key to the journal abreviations is being prepared, and will be displayed alongside the index, although it is thought that a large number of the titles are self-evident, vis. B.M.J., B.H.J., B.J.S., etc. There is no author entry. Experience

has shown that readers more often ask for subjects than authors, and if the search is for an author the *Index Medicus* should be used.

There is also no mechanism for issuing a regular list. A daily list was given a trial run, but the library staff are insufficient to devote the time to its preparation. We are also unable to index "in depth", that is, the number of entries per article is limited usually to two. This cannot compare with the ten possible entries of MEDLARS, but does compare with the three of *Index Medicus*. The journals are limited to those being received in the Wills Library, that is, about 250, but it is hoped that gradually other journals taken in the hospital and school will be included so that the total will approach 550-660. This must obviously depend on staff and time being available.

One advantage that we can claim over other systems is the speed at which references are stored. Within hours of a journal being received in the library the contents may well be indexed and included in the system.

We hope that we will be able to supply, within minutes of a request being received, a list of such papers as are available in the library and ultimately in the hospital. Obviously the longer the scheme is in operation the larger number of references that can be supplied and during the next few months as much information as possible will be stored in the system.

It must be appreciated that the Wills Library scheme in no way replaces the *Index Medicus*, etc., for the serious reader who has to cover the whole literature. The Wills Library scheme will produce locally available papers within minutes, but for a complete coverage of the literature available the *Index Medicus* is still necessary.

Literature retrieval is a two-way process, and depends on feed-back to the source. The scheme is for the use of our readers, and comments and suggestions are more than welcome.

The author is very grateful to two members of the Wills Library staff for their help in getting this scheme going, and its continuation. Mrs. Jean Moore, over the past few weeks, has prepared the many thousands of guide cards which form the skeleton of the index, and Miss Rosalyn Mansell types the slips for incorporation in the index. If this scheme develops and becomes a useful service it will be due to their co-operation.

The Art Society Exhibition

My first impression of the annual exhibition of the Art Society in the Gordon Museum was of its size. It was perhaps a little disappointing to find that this excellent display depended mainly on a comparatively small body of prolific artists. I am certain that there must be many painters and sculptors at the hospital who fail to exhibit because they feel their work is not of sufficient interest. This is a pity as it limits the scope of the exhibition and deprives us of the interest of seeing their work.

Landscapes dominated the exhibition, most of them apparently executed during the summer. Perhaps the small number of still life, portrait and imaginative work reflects the lack of leisure time during the winter months. Many of the landscapes and river scenes were pen and wash and showed a high standard of competence. I particularly like the work of Neil Watson and Paul Telling. Both handled the difficult combination of line and colour delicately and energetically. Neil Watson's river scenes conveyed well the different moods of the Thames, he showed a dark, rather heavy "Hammersmith" and a lighter, quieter "Rotherhithe". Also excellent was his pen drawing of Southwark Cathedral. A variation on the same theme was provided by his large paintings on board, using plaster as texture and thin, subdued colour. I was not altogether happy about this combination. The use of plaster was more successful in his abstract, where the clear, bright colour provided a better balance to the texture. Paul Telling showed some convincingly floating boats and various landscapes. His "View of Beilstein" had something of the quality of an old print. Also interesting was his "Day in the Gasroom", I liked its lively, economic use of line which was unfortunately lost in those works where he used a felt pen.

Although the pen and wash was so impressive as a group, it was an oil painting which made the most immediate impact, "The Gladiators", by R. F. Wilson. His use of rectangular lozenges of colour gave an "op" effect on the red and yellow stripes of the football jerseys. A portrait using small points of colour was not so successful but it was good to see a not entirely conventional approach to the use of paint. He also showed an excellent drawing of a nude.

Trees were the theme of paintings by Henrietta Pels and Mrs. C. Wilson. Their difference in treatment of the subject was interesting. Miss Pels handled her paint well to evoke a quiet, still scene, while Mrs. Wilson used live, intense greens and saw her trees as very solid. Mrs. Wilson also showed a large number of prints. I particularly liked the one of Oast Houses.

Compared with the amount of pictorial exhibits there was very little three dimensional work shown. There was a pleasant group of pottery by Miss Pels, some small pieces of sculpture by R. F. Wilson, and a fine yellow wire grasshopper by Nigel Thompson. I should like to have seen more of this type of thing and, in fact, altogether more experiments with materials and ideas, even perhaps some "op" and "pop".

M. R. CAMERON.

CORRESPONDENCE

The Churn

SIR,—We had been playing London Hospital. As has been stated, the trains from Richmond stopped at Vauxhall for ticket collecting. I, with " Rudolf " Warner, Archie Peaty and Victor Spill, was in the compartment just behind the one containing Reggie Curle, Hancock and two or three other medicals. While waiting, Reggie, Hancock, Hunot and Warner got out of the train, grabbed the churn and took it into their compartment. There was a story days later that they had also grabbed a porter, pulled him into the train, debagged him, and put him out on the platform again, but that I think is a fable. Anyway, we did not see it happen. At Waterloo the churn was placed at the head of a group of returning students and carried down to the Hospital, where it was cleaned up and put in the spit. This group increased in numbers on the way from Waterloo to Guy's, but it was orderly—no horseplay and no police. There was a small restitution fund started to heal the wounded feelings of the porter and for the churn. I cannot ever remember it being known as the " milk can ".

Yours, etc.,

S. W. INGRAM, L.D.S.

1, Union Crescent,
Margate.

The Milk Can

SIR,—I have read your article entitled " The Mystery of the Milk Can", compiled by Mr. G. Winston in the *Gazette* of 19th March, 1966. I should like to make some comments on this article.

I am certain, in my own mind, the milk can was seized by Reggie Curle (together with Allen Hancock, I am prepared to accept) from a collection of milk cans standing on the platform of Clapham Junction Station. The can was seized on the return journey from Richmond to Waterloo, after winning the Inter-Hospitals Cup Final against the Middlesex, March, 1909, not March, 1908. I went up to Guy's in my third year, October, 1908, and was Surgical Ward Clerk on Mr. Charters Symonds' Firm. I was not at Guy's, March, 1908.

I was present in March, 1910, when we took the can to Richmond Park under strong escort for the Inter-Hospitals Final between Guy's and the London. The milk can was paraded around the field; Allen Hancock climbed up one of the goal posts and then hung the can on the crossbar. The Prince of Wales was present and he appeared to enjoy the fun.

I cannot agree with the conclusion as stated in the last paragraph of G. A. R. Winston's article. I am quite convinced that the milk can was seized in March, 1909, on the return journey from Richmond to Waterloo, and that the can never saw Richmond until March, 1910.

I was glad to receive a letter from George Genge-Andrews reminding me that he, too, was present at what he now so aptly calls " The Great Milk Can Robbery". I was also glad to hear from E. A. Penny. He says: " No doubt you are right as to the details, e.g., Clapham, as the scene of the incident, and not Vauxhall". He also reminds me that C. Reckitt was in my compartment on the train.

Yours, etc.,

H. V. LEIGH.

Nottage House,
Nottage,
Porthcawl,
Glamorgan.

Acupuncture

SIR,—Dr. Mathias is to be congratulated on his excellent review of this subject written when he was a student.

Unfortunately, it has given rise to considerable misunderstanding and has been widely misquoted in the popular Press.

I would therefore like to take up some of your precious space in stating the exact situation with regard to the trials of acupuncture carried out in the Department of Physical Medicine in Guy's.

In 1961 my registrar, Dr. C. Barry and myself, made a study of the techniques of acupuncture and subsequently conducted carefully controlled trials on the use of this technique in the treatment of rheumatoid arthritis, osteoarthritis and intervertebral disc prolapse.

Our results showed quite definitely that acupuncture is of no value whatever in affecting the course of these diseases. Patients occasionally experienced a temporary improvement of their symptoms, but this was not substantiated by any change in the clinical picture, serological findings, or as it subsequently turned out, in the long-term course.

Whilst conducting these investigations, we also tried the effect of acupuncture in several patients who were suffering from predominantly functional and hysterical disorders, with skeletal manifestations. Several of these patients unquestionably did improve, but we have not continued to treat this type of condition as it is felt that there are alternative, more satisfactory forms of management to be offered by the Department of Psychiatric Medicine.

Therefore, it is our considered opinion that acupuncture has no part to play in the treatment of organic bone or joint disease, and for this reason the technique is certainly not practised in my Department.

Yours, etc.,

P. HUME KENDALL.

Keats House,
Guy's Hospital,
London, S.E.1.

British Medical Students' Association

SIR,—The British Medical Students' Association is holding its National Medical Conference in London between April 13th and 16th.

The Conference is to be entitled " Perspectives in Medicine", and we have attempted, with a great deal of success, to invite some of the leading members of the profession to take part. They include Dr. G. Swyer, Mr. P. Diggory and Dr. P. M. F. Bishop, who will be speaking on matters connected with obstetrics at the Royal College of Obstetricians and Gynaecologists on the morning of Wednesday, April 13th. In the afternoon, Dr. D. Stafford-Clark, Dr. G. F. Vaughan and Dr. H. Wolff will be taking part in a Psychiatric Brains Trust at the Royal College of Physicians. The evening will be spent at Guy's with a wine and cheese party followed by a film on oral contraception and a discussion with Dr. P. M. F. Bishop chairing a panel of doctors acquainted with the situation. On Thursday morning there will be a demonstration on medical automation organised by the Experimental Unit of Elliott Electronics Ltd., and the afternoon will be spent at the College of General Practitioners. On Friday morning Professor H. J. B. Atkins, Sir Brian Windeyer and Dr. C. Negroni will be speaking on aspects of cancer, and in the afternoon Mr. Charles Drew will talk on cardiac valve replacement, followed by a demonstration on limb prostheses by Dr. I. Fletcher. The day will be spent at the B.M.A. On Saturday morning there is to be a clinico-pathological meeting at U.C.H.

I hope that students will make a special effort to attend some, if not all, of the sessions, especially as there will be four consultants from Guy's speaking. Admission is absolutely free.

Further details can be obtained from me or the B.M.S.A. (EUS. 4499).

Yours, etc.,

R. H. S. LANE,
Convenor.

East Wing,
Guy's Hospital, S.E.1.

Boxing Club

SIR,—I attended the boxing match in the Pavy Gymnasium on Tuesday, 22nd March, when Guy's boxed members of the Lynn A.C. and the Fitzroy Lodge A.B.C. and won by a convincing margin.

It was especially pleasing to note the new talent which is showing in the Club. With a number of the more experienced boxers leaving this year, there was a fear that new intakes would not fill the gaps in the coming year. However, it is seen that the sport is still popular amongst the students, and with the centenary year coming in 1971, every opportunity must be taken to build the Club into a force to be reckoned with amongst the Universities.

Let us go all out to encourage new members to participate and take advantage of the training provided by Charlie Packnell, our hard-working coach.

This is the oldest boxing club in the world, and its continuation must be ensured.

Yours, etc.,

W. M. SHEERAN.

262, Portland Road,
London, S.E.25.

NOTICES

The Thirty Club

The Annual Dinner of the Thirty Club will be held on Friday, May 20th, 1966, at the Royal Air Force Club. Dr. G. B. Dowling in the chair.

Detailed notices have been sent to all members. Will those members who have not yet replied, please do so as soon as possible.

J. J. CONYBEARE.
W. D. DOHERTY.

1964 Club Dinner

A Dinner has been arranged for Wednesday, 6th April, 7.00 to 7.30 p.m., at the Mayflower, Rotherhithe. Any member who has not received a personal invitation should contact me as soon as possible.

Robert J. Hart, The Mildmay Mission Hospital, Hackney Road, London, E.2.

The Innominate Club

The next Dinner of the Innominate Club will be held on Friday, 20th May, 1966, at the Bath Club. Mr. A. T. Fripp will be in the chair. For tickets, please apply:—

G. T. Hankey, Esq., 89, Harley Street, London, W.1.

Annual Dental Clinical Meeting, March 5th, 1966

The morning of March 5th, 1966, dawned bright and springlike, and as the alumni converged on their Alma Mater for the Annual Dental Clinical Meeting in the forecourt and the restored buildings, now beginning to mellow, looked their noble best.

The number of old Guy's men attending was as great as ever. This year the number of demonstrations was, by design, reduced. This, however, did not detract from the quality. All Departments put on demonstrations and, as usual, it is extremely difficult to single out any for special mention. There were the usual operations carried out in theatres and in the demonstrations by the visiting dental surgeons, and these attracted good audiences. The other demonstrations ranged from advanced operative procedures, endodontic therapy and orthodontic problems. Amongst the scientific demonstrations on display were those by Professor D. J. Anderson and his team from the Department of Physiology. The most spectacular of these was the demonstration of action potentials taken from the nerves within the pulp of the tooth. This is the first time that such a

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(The Wellcome Foundation Ltd.)

phenomenon has ever been demonstrated, and undoubtedly marks a major advance in the field of sensory physiology of the teeth. In addition to the clinical and scientific demonstrations there were those which dealt with teaching techniques. The use of the 8 mm. film in the teaching of operative dentistry was shown by Mr. A. D. Robinson; aspects of visual aids in the teaching of children's dentistry were exhibited by Mr. S. P. Johns, and the construction of demonstration and teaching models in connection with prosthetic dentistry was demonstrated by Mr. Gain, Mr. Morris and Mr. Cragg.

This year the preprandial lecture was given by Dr. Thomas Lehner, Senior Lecturer in the Department of Dental Medicine, who spoke of recent advances and management of recurrent oral ulceration. This lecture was well attended and much appreciated by the audience.

Lunch followed in the old familiar places which varied from the Staff Common Room, where the usual Clinical Day cold ham and chicken salad was served, to " The George " with bread and cheese, and beer. Those who lunched in the Staff Common Room were delighted to learn that Clinical Day, 1966, marked the 81st birthday of Mr. F. N. Doubleday and saluted the occasion appropriately by wishing him "Happy Birthday" in song.

The afternoon began with the traditional lecture from the Department of Dental Medicine, " Cases You Have Sent". This year, Dr. R. A. Cawson, deputized for Professor Martin Rushton, who unfortunately was not able to be present. As usual, the Lecture Theatre was full to capacity with an audience who greatly appreciated Dr. Cawson's most interesting and lucid presentation. At the conclusion of the lecture there was still time for a quick walk round the Dental School to have a last look at the demonstrations before repairing to the East Wing for tea.

Clinical Day throws a heavy burden on many people, not least of whom are the maintenance and administrative staff of the Dental School, the Dental Photographic Department and the Department of Medical Illustration. Their co-operation and hard work is an essential ingredient for the success of the day and is much appreciated by all.

M. N. NAYLOR.

Residents' Ball

The Residents' Ball will be held on May 13th at the Grosvenor House, Park Lane. Dancing will be to Bill Saville and his Band, and the cabaret will be by Cambridge University " Footlights ". Double tickets at 5 guineas, which includes dinner, are available from Mr. Goodliffe at the Appointments Bureau, or from A. M. Roberts at the East Wing.

P. D. DAVIS,
Sec., Ball Committee.

SPORT

In our last issue, the approaching termination to the winter sporting programme prompted a preliminary review of the Hospital's accomplishments. Now the season has all but ended and we have indeed rounded off the successes reported last time with splendid victories in both the Rugby Cup Final and the Soccer Cup Final. In defeating St. Thomas's 3—0, our tally moves to 29 wins since the Rugby Challenge Cup was introduced in 1875—12 more than our nearest rivals. It was a thoroughly deserved victory in a game played at a far higher standard than we have become accustomed to in Cup matches of recent years. The team and John Davies, its captain, deserve the highest praise.

The Soccer XI produced their very best form to win 2—1 in extra time against The London, having met them only five weeks previously when they suffered a 5—0 defeat. It has been a troubled year for the Soccer Club, the severe shortage of experienced players causing numerous remodelling problems at a time when results were far from encouraging. It is consequently of even greater credit to the Club Captain, Elwyn Elias, that his side has so triumphed in the Hospitals' Cup.

The Rugby Club, in fact, have two more achievements to boast. On Saturday, March 19th, the 1st XV defeated a strong Gloucester side 12—5, and on Sunday, March 27th, the U.H. seven-a-side tournament was duly won, the captain, J. A. Edgar, fittingly converting the try scored on time to defeat St. Mary's 16—14 in a most exciting final. Earlier in the season we were pleased to offer our congratulations to W. T. Treadwell on his gaining an England cap. It is equally pleasing to announce that our other International trialist, C. W. Thorburn, has been invited to tour Wales with the Barbarians this Easter. We wish him well—he will certainly have a busy time, for he is also visiting Wales with the British Universities' XV

The Boxing Club has entered upon an encouraging revival. On Tuesday, March 22nd, seven of our boxers met a selection of opponents from the Lynn and Fitzroy B.C., six of them winning in well-fought contests. The Hockey Club unfortunately seem plagued with an end of season apathy that has led to four successive disappointing defeats. While most of the winter sportsmen seem content to hang their boots up for the summer, the "A" XV are busily engaged in organising a tour to North Wales, where the *après* rugby will no doubt assume customary undue prominence.

REPORTS & RESULTS

RUGBY

Cup Final

GUY'S v. ST. THOMAS'S

At Richmond. Thursday, March 17th, 1966

Result: won 3—0

For those who were privileged to watch this replay of the Hospitals' Cup Final, it was one of the rare occasions in Cup Rugby when the triumph of victory had been preceded by not only a match of unrelenting and determined rugby but one containing highlights of brilliant play. The student of rugby is often content with appreciating the details of dour forward battles, but even the uninitiated must on this occasion have been thrilled by the excitement of open movements, skilled forward rushes, and at times of brilliant fielding and kicking.

It was a perfect day; thoughts were on the rugby and not the rag, and the opening twenty minutes set the tone for the remainder of the match. In sharp contrast to the previous game, Guy's immediately dominated possession from the line-outs, scrums and loose, and the ball moved rapidly to the wings, giving all the backs the feel of the ball. The St. Thomas's back row were drawn out, leaving our halfbacks a little more time to act, and this failure of the opposition to dominate our halves continued throughout the game and was probably one of the decisive factors in our keeping the territorial advantage for the major part of the match. Our back row, and Swift, at scrum-half, smothered any St. Thomas's move. The opposition's defence as usual was excellent, and even the speed of Morgan and power of Egwuatu on the wings could not penetrate to their line. A Guy's line-out infringement near half-way resulted in an anxious moment as the penalty kick went just wide, and this encouraged St. Thomas's who dominated play in our twenty-five. Three five yard scrums were won by our opponents and two of the three attempted drop goals went uncomfortably close. Elliott's long touch kicking from full-back relieved the pressure, however, and honours were then shared for a time with play between the twenty-fives. The hardworking pack was still dominating possession and Rowlands, with high floating kicks and the centres with short kicks ahead, began to extend the St. Thomas's defence. Play moved up to their goal-line when Edgar was forced into touch five yards out after a movement during which Guy's won the heel from a set and two loose scrums in rapid succession. St. Thomas' pushed back to near half-way, but a

threequarter movement met fierce Guy's tackling, the ball ran loose with Lindsey and Morgan keeping it in play, and Stansfield was well up to kick ahead. The St. Thomas's full-back fumbled under pressure from our pack and his kick kept low for Rowlands to snatch the ball up and go over in the corner. The attempt at conversion was wide, and Guy's led by 3—0 after 35 minutes. St. Thomas's rallied and attacked furiously around the base of the scrum, but our back row was faultless in defence.

The second half opened with St. Thomas's attempting handling movements between forwards and backs, particularly after the short line-outs, but these were thwarted by efficient tackling and almost inevitably the speed of our pack resulted in possession from the loose scrums. Play thus moved into the St. Thomas's half of the field and any potential threat from the opposition by kicking ahead was brilliantly handled by Elliott. Throughout the game his positioning was outstanding, handling faultless, and as often as not the return kick, be it right or left foot, took play right back into the St. Thomas's half. This, above all, broke the morale of the opposition in attack and for most of the last quarter Guy's pressed hard. One movement near the end almost resulted in a score after a good break by Edgar from a loose scrum, and well timed passing by Rowlands and Lindsey gave Egwuatu the chance to burst through two defenders and cross the line, only to be called back for a forward pass. The final whistle gave a narrow but impressive victory.

As always in Cup rugby, relentless defence makes scoring difficult, and possession of the ball becomes all important. Credit must go to the pack whose fitness, speed, and sure handling allowed the backs to initiate so much attacking rugby. Individually there were no weaknesses, and John Davies must be congratulated on the effort and skill he has contributed throughout the season to develop this side into such an effective team. The standard of play and results have been consistently better than for many years, and this has been reflected in the results throughout the Club. The first team pack against St. Thomas's dominated the tight. Hey took the ball against the head on a number of occasions and played a valuable part in the loose. Stansfield showed remarkable speed around the field and he and Davies are now experienced props and won the honours against a distinguished St. Thomas's front row. Kingdon and Peace controlled the line-out and provided most of the power in the mauls. Cockburn played his best game yet at number eight, and Sharp was everywhere in the loose, having seemingly endless energy. Thorburn, on numerous occasions, was in the right place to initiate an attacking movement or cover in defence, and his experience has been of tremendous value to the side. Swift, at scrum-half, stood up to a battering from the opponents' forwards without flinching, and his defensive kicking was invaluable. The threequarters made few handling mistakes, kicked very effectively, and were always dangerous when in possession.

Team: D. R. Elliott; J. Egwuatu, M. Lindsey, J. A. Edgar, I. J. Morgan; B. J. Rowlands, P. G. F. Swift; J. E. Davies (Capt.), G. B. Hey, R. Stansfield, A. J. Kingdon, P. K. Peace, H. C. Sharp, J. M. Cockburn, C. W. Thorburn.

S. A. R. COOKE

GUY'S v. NUNEATON

At Nuneaton. Saturday, March 12th, 1966

Result: drew 6—6

This was Guy's last match before the Cup Final replay with St. Thomas's, and hence a good result from this match would have given the team that extra bit of confidence before their most important game of the season. This game with Nuneaton was drawn, which was a very satisfactory result considering six reserves were playing, but on the other hand the game should have been won easily in the second half.

Nuneaton kicked off into the wind and sun on a beautiful spring day, with conditions underfoot perfect for open rugby. Guy's were soon on the attack and early on were awarded a penalty for a scrum infringement. Morris kicked this penalty to give Guy's an early lead.

After this Nuneaton gradually got on top in the first half and after a quarter of an hour they were awarded the first of two penalties in a matter of minutes. The first attempt hit a post and bounced back into play. Guy's carried the ball over their own line and touched down. From the resulting five-yard scrum, when Hey took the ball against the head, Rowlands made a fine break and took the ball up to Nuneaton's '25'. Unfortunately, Guy's were immediately driven back to their own '25', and were then penalised for the second time, this time for a line-out infringement. This attempted shot at goal also failed.

Nuneaton continued to attack but did not look particularly dangerous until their fly-half was allowed to make a fine break, evading three tackles. His pass inside was intercepted by a Guy's forward who ran behind his own line and in attempting to kick for touch, only managed to kick it straight in the air, and one of the Nuneaton players caught the ball and touched down for a lucky try. The conversion attempt was wide.

After this equalising score, Nuneaton continued to press hard, and were awarded a penalty in front of Guy's posts for offside. The Nuneaton full-back converted easily to give Nuneaton a 6—3 lead, and this they maintained to half-time, although Morris missed another penalty given for offside against the Nuneaton scrum-half.

The second-half began similarly to the first with Guy's being awarded a penalty for offside against the opposing scrum-half. Morris missed this penalty, as he was to miss several others in this half, some of which were only just wide. The Guy's back row were holding the ball often in the tight and catching the Nuneaton scrum-half offside on numerous occasion.

Guy's were soon beginning to play with more authority and determination and, apart from their numerous near misses with penalty attempts, nearly scored tries on two or three occasions. One fine movement by the backs should have resulted in a try, but Edgar, instead of making for the corner which was well within his reach, passed inside and the movement broke down. Guy's continued to press hard for an equalising score and were thwarted until the last minute of the game, when one of the opposing wing-forwards for a change got offside, and Morris got this one over. Thus Guy's only just managed to draw a game they so easily should have won.

Guy's Team: A. R. Morris; K. Brown, R. J. Beacham, J. A. Edgar, M. Cheesbrough B. J. Rowlands, P. G. F. Swift; J. E. Davies (Capt.), G. Hey, R. Stansfield, A. J. Kingdon, P. K. Peace, H. C. Sharp, C. Neville, D. Curson.

G. E. RATCLIFFE

GUY'S v. GLOUCESTER

At. H.O.P. Saturday, March 19th, 1966

Result: won 12—5

In the match following their last Cup Final win, Guy's beat Aberavon. This year it was Gloucester's misfortune to have to play Guy's after Thursday's great Cup win.

Guy's made two changes from their Cup winning side, Neville and Beacham replacing Peace and Lindsey. Gloucester's only absentee was Rutherford, who was playing at Murrayfield.

Guy's won this game deservedly by two tries and two penalty goals to one penalty try, with the whole team playing splendidly, particularly Beacham whose tackling in the centre was first-class and whose two side-steps brought tries for Thorburn and Egwuatu.

There was beer in the air as Guy's kicked off downfield, and for the first few minutes play swung from '25' to '25'. The crowd was disappointing in size, but was swollen at one end by a nursery of babies whose vocal support was not lacking in volume, but it was difficult to decide for whom they were screaming. Both sides tried to fling the ball about, Guy's being the more successful as the Gloucester fly-half seemed to be very reluctant to receive the ball. The Gloucester front-row seemed to have the measure of the Guy's front-row, and by the end of the game had taken six-to-one against the head. Guy's seemed to have a little trouble up front and were penalised on a few occasions for foot up. From one of these resulting penalties the Gloucester full-back tried but failed to put his side ahead.

Gloucester had the more chances in these early stages with their scrum-half giving a superb service to his stand-off. The latter was more interested in drop-goal attempts than passing the ball out, all these kicks being fruitless.

About midway through the first half Guy's got the ball back clearly from a scrum near the halfway line and Rowlands put Edgar away. He kicked through, Beacham gathered and after one superb side-step, put Thorburn clear for a very fine try. Elliott narrowly failed to convert.

Gloucester's attacks began to look a little more dangerous now, but Guy's defended magnificently with the centres, especially Beacham, making some very fine tackles. However, Guy's were penalised on their 25-yard line, but the penalty attempt was badly muffed. Guy's attacked again and were awarded a penalty when Egwuatu was obstructed, and Elliott, who was playing his usual fine game, kicked this penalty to give Guy's a 6—0 lead, which they maintained to half-time after Gloucester had missed two further penalties.

Early in the second half Gloucester pressed hard for a try, but all attempts were thwarted by a fine Guy's defence. At one point that one-footed full-back, Elliott, cleared superbly with his left foot—which brought at least two curtain calls!

However, Gloucester continued to press hard and were awarded a penalty try when Elliott prevented one of Gloucester's players from touching down a loose ball over Guy's line. Apparently one of Gloucester's players had carried the ball over the line, but knocked on only for another player to dive for the ball—but here Elliott had intervened. The try became a goal to cut Guy's lead by one point. The decision to award a penalty try was an odd one by the referee; he had made some strange decisions before this incident, and by the end both sides were somewhat exasperated by him.

At this point, with Guy's leading by one point, Gloucester at last began to live up to their reputation. Gloucester had not played badly, but Guy's had played better, particularly in defence. On two occasions Guy's cleared by fine foot rushes, led firstly by Sharp and secondly by Morgan. On both occasions Gloucester were awarded scrums for knock-ons on or near their line.

Guy's slowly got on top again and began to play some sparkling open rugby. One movement in particular was an example of the highest class of open rugby played by a side which is now playing with confidence and the success it deserves. In this movement the ball was passed back and forth across the field four times between the pack and threequarters, ending with Egwuatu being pushed into touch just short of the Gloucester line by the full back. What a pity this movement did not quite bring the try it deserved.

Soon afterwards Guy's were awarded a penalty under the posts, when one of the opposing centres was up too far at a set scrum. Elliott scored easily to make the score 9—5. Both sides tried hard for further tries, and Beacham capped a fine performance by making a fine side-step before putting Egwuatu away, who scored in the corner. Elliott missed the conversion. The last few minutes were spent with Gloucester trying to reduce the deficit without success.

This was a well-merited win by Guy's who played with the confidence and skill a cup win always brings.

Guy's Team: D. Elliott; V. E. Egwuatu, R. J. Beacham, J. A. Edgar, I. Morgan; B. J. Rowlands, P. G. F. Swift; J. E. Davies (Capt.), G. B. Hey, R. Stansfield, C. G. Neville, A. J. Kingdon, H. C. Sharp, J. M. Cockburn, C. W. Thorburn.

G. E. RATCLIFFE

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL
June 1st, 1966

Applications are invited for the following House Appointments at Guy's Hospital, due to begin on June 1st, 1966, applications giving choice of post and choice of hospital, in order of preference, to be lodged with the Superintendent, not later than **April 29th, 1966.**

Assistant House Surgeons
Pre-registration 4

The appointment will be for six months, the first three to be spent as A.H.S. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Surgical) or will remain as A.H.S.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Assistant House Physicians
Pre-registration 5

The appointment will be for six months, the first three to be spent as A.H.P. During the second three months of the appointment candidates will move either to the post of Casualty Officer Medical) or will remain as A.H.P.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Casualty Officers
Pre-registration 6

House Surgeon to the Surgical Unit
Pre-registration 1
(2nd six month)

House Surgeons 2
1 Pre-registration
1 Pre- or Post-registration

House Physicians 3
2 Pre-registration
1 Pre- or Post-registration

Resident Obstetrician
Post-registration 1

Throat and Ear House Surgeon
Pre- or Post-registration 1

Orthopaedic House Surgeons
Pre-registration 2

Genito-Urinary House Surgeon
Pre-registration (2nd six months) or post-registration 1

House Surgeon to the Thoracic Unit
S.H.O. 1

Children's House Physician
Pre-registration (2nd six month) or post-registration 1

House Physician in Clinical Pathology
S.H.O. 1

House Physician in Child Psychiatry (part-time Guy's, part-time Evelina)
Post-registration 1

R.M.O. Nuffield House
S.H.O. 1
(To commence on 1.7.66)

Resident Anaesthetists
S.H.O. 2

Children's House Physician at the Evelina Hospital
Post-registration 2
1 to commence on 1.6.66.
1 to commence on 1.8.66.

ST. OLAVE'S HOSPITAL

House Physician to Dr. Mason and Dr. Cox
Pre-registration 2
(From 1.7.66)

House Surgeon to Mr. O'Flynn
Pre-registration 1
(From 1.7.66)

House Surgeon to Mr. Lewys-Lloyd
S.H.O. 1
(Recognised for F.R.C.S.)

House Physician
S.H.O. 1

NEW CROSS HOSPITAL

House Physicians in General Medicine and Geriatrics 2
1 S.H.O
1 Pre-registration

Orthopaedic House Surgeons 2
1 S.H.O.
1 Pre-registration

The Medical Committee will also consider applications for appointments at outer hospitals as follows:—

LEWISHAM HOSPITAL

House Surgeon to Mr. Lynn-Evans
Pre-registration 1
House Physician to Dr. Price
Pre-registration 1

ORPINGTON HOSPITAL

House Surgeon with Gynaecology
Pre-registration 1
House Surgeon with Orthopaedics
Pre-registration 1

PEMBURY HOSPITAL

House Surgeons
Pre-registration 2

ST. JOHN'S HOSPITAL, LEWISHAM

House Surgeon with Gynaecology
Pre-registration 1
(To commence 1.6.66)
House Surgeon with Gynaecology and Orthopaedics
Pre-registration 1
(To commence 1.7.66)

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's, therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts is available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectively. A candidate who has completed his first six months in a specialty (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

R. J. CANN,
Acting Superintendent.

March 28th, 1966.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Registrar in the Dental Casualty Department,** to attend on six sessions per week, with duties to commence 1st May, 1966, or as soon thereafter as possible. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Tuesday, 12th April, 1966.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the following appointments to commence duties on 1st October, 1966:

Dental Research Fellow (full-time) (Lecturer Grade) in the Department of Dental Medicine;

Lecturer (full-time) in the Department of Dental Prosthetics.

Salary in the scale £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535 with superannuation.

Forms of application are available from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later later **Tuesday, 26th April, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the following appointments to commence on 1st October, 1966:

Department of Conservative Dental Surgery.
Registrars to attend full-time or part-time.

Department of Dental Prosthetics.
Registrars to attend on six, five, four, or three sessions per week.

Dental Department for Children.
Senior Registrar to attend full-time.
Registrar to attend on six sessions per week.
Orthodontic Assistant to attend on six sessions per week (Registrar Grade).

Clinical Dental Surgery (including Oral Surgery).
Senior Registrars/Registrars to attend full-time.

Department of Preventive Dentistry.
Registrars to attend on six, five, or three sessions per week.

Casualty Department
Registrars to attend six or five sessions per week.

Minor Oral Surgery Department.
Registrars to attend on six or three sessions per week.

Dental Radiology Department.
Registrars to attend on six, five or three sessions per week.

Dental Officer to Treat In-Patients.
One Dental officer to attend on six sessions per week.

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Tuesday, 26th April, 1966.**

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Miss A. Anderson — Miss J. Hankinson
Miss L. Evans — Miss L. Rogers
Miss A. Parker

ENGAGEMENT

The engagement is announced between Miss Susan Osborn and Mr. David Beale (Dental School).

BIRTH

OSMOND-SMITH.—On 13th March, at St. Richard's Hospital, Chichester, Sussex, to Susan and Dudley Osmond-Smith, a son, Martin.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

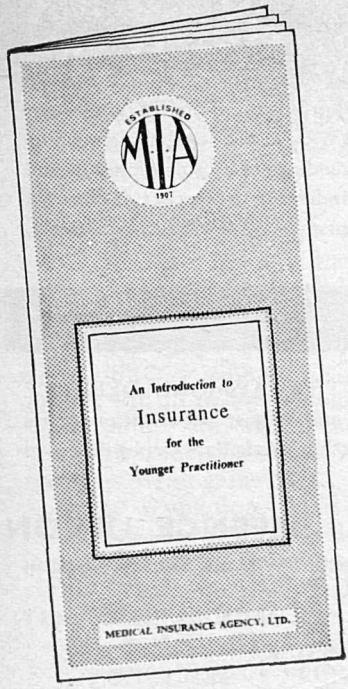
CHANGES OF ADDRESS

POCOCK.—Now Mrs. P. E. Halford, of "Rigi", High Street, Canewdon, Essex.
PEARCE.—R. H. Pearce, L.D.S., R.C.S., to 85, Guildhall St., Bury St. Edmunds, Suffolk.
WEBB.—Dr. and Mrs. R. A. J. Webb, to Gladesville Hospital, Gladesville, New South Wales, Australia.

DEATH

MACKENZIE.—Murdo Mackenzie, M.D., M.R.C.P., died on March 4th. Dr. Mackenzie qualified at Guy's in 1922 and was consulting physician in Psychological Medicine at St. John's Hospital, Lewisham.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT D. J. HENDRICK
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2027



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Separate Tables

"At Guy's Hospital there is a large and comfortable sitting-room for the use of nurses, well furnished with easy chairs and newspapers and magazines, and provided with a grand piano.

"Social organisations, such as the cycling club, tennis and croquet club, library, choral society, debating society and photographic society are in a flourishing condition and provide nurses with many opportunities for widening their interests."

This quotation comes from a book entitled "The Lady's Realm", and was written in 1905. After sixty years of world upheaval and scientific revolution, there have been many changes in the social amenities at Guy's. The most recent of which has been the inspired conversion of the former site of the Old Miller into a hard tennis court. Yet, as in 1905, each sector of the community is still carefully compartmentalised so that they eat apart, have comfortable sitting-rooms apart, and consequently think apart. With the important exception of the park in the summer and a few of the more successful societies such as the Theatre Club, there is still little, if any, common meeting ground for all the various members of the Guy's community. And outside the strict confines of the inevitable romances, contact between each of the different professions only occurs within the context of work.

This is unfortunate for, as Medicine itself progresses, it is becoming more and more clearly a team operation, the success and effectivity of which will require an ever-increasing co-operation at the professional level. More satisfactory social intercourse can do nothing but enhance this co-operation and so indirectly help towards the main aim of providing the best possible patient-care. However, as was so lucidly pointed out by Professor Hubble in a recent B.M.J., the doctor may well have cause for being reactionary as regards this humble integration, for his public image and satisfactions have so long been built around a splendid isolation. Nevertheless, a beginning might be made if all the hospital's comfortable sitting-rooms became shared territory. Then, who knows, by the year 2025 we might integrate the Spit with the Nurses' Dining Hall.

C. S. Forester

We were pleased to receive the following account of C. S. Forester from Dr. Talbot-Rogers, who was Editor of the *Gazette* in 1921.

Cecil Foster-Smith, later to adopt, and become universally known by the pen-name of C. S. Forester, was a medical student at Guy's intermittently from 1916-1922. He never had any great personal urge

to study medicine; writing was already his ambition; but he came from a medical family—one elder brother had already qualified from Guy's—and to Guy's he was sent to follow after him. His medical studies were never completed. Setbacks in his pre-clinical examinations were punctuated by excursions into journalism, and into biographical research and writing. While still at Guy's he contributed to "The Gazette" some short studies on hospital life, which were to be his earliest published works.

Later he turned to writing fiction and achieved his first notable success with "Payment Deferred". This work, a psychological study of a murderer, was dramatised and a young actor, Charles Laughton, newly come to London, appeared in its first production. It was subsequently filmed, as were so many of his later books, such as "Brown on Resolution", "The Gun", "The African Queen" and the Hornblower novels.

Forester had an amazing ability to introduce into his stories a background of such convincing detail that they came to sound almost as though they were autobiographical. This is, perhaps, nowhere better seen than in "The General", which is regarded by many critics as his best book. Forester's descriptions, in this book, of life in, and behind the lines in Flanders in 1917-18 are so real as to make it difficult to believe that he spent those years, not in France, but in the dissecting-room at Guy's.

A.T.R.

Dr. R. H. Gorrill has had the title of Professor of Bacteriology conferred upon him by the University of London.

On Friday, the 1st of April, the Medical School was host to the Osler Club for a meeting in celebration of Hodgkin's Centenary. One of the papers delivered before the club on this occasion was given by Dr. Hardwick and we hope to publish this in a forthcoming *Gazette*.

It is with deep regret that we report the death of W. D. Doherty, who was Superintendent of the Hospital from 1948 to 1958. An obituary will appear in the next *Gazette*.

GUY'S DIARY

APRIL			
18th	M.	1.00	Dr. B. BAKER, M.D., Johns Hopkins Hospital. Clinical Lecture. "Angina Pectoris".
19th	T.	1.00	Dr. WAYTE. Clinical Lecture.
21st	Th.	1.00	Mr. GLOVER. Clinical Lecture.
22nd	F.	1.00	Dr. B. BAKER, M.D., Johns Hopkins Hospital. Clinical Lecture. "Risk Factors in Ischaemic Heart Disease".
25th	M.	1.00	Lord BROCK. Clinical Lecture. "Post-operative Chest Complications".
26th	T.	1.00	Mr. ECKHOFF. Clinical Lecture. "Deformities of the Hands'.
28th	Th.	1.00	Professor MAHLER. Clinical Lecture. "The Glycogen Storage Diseases".
29th	F.	1.00	Dr. HOUSTON. Clinical Lecture.

COMMUNITY PSYCHIATRY

by

Dr. Arthur Oldham

Department of Psychological Medicine, St. Olave's Hospital

Some Historical Milestones

The history of psychiatric community care embraces the changing attitude of society towards mental illness throughout the ages. Recent studies of primitive societies in Africa and elsewhere has shown how abnormal behaviour may express itself in the cultural pattern of the tribe whilst animistic beliefs enter freely into the society's reactions to such behaviour. Tribal reactions depend largely upon local custom and may vary from tolerance to extermination with the witch doctor acting both prosecutor and therapist.

With the progress of civilisation, increasingly sophisticated ideas in regard to man's environment have led to the gradual abandonment of animism. In Europe the effect of Christianity was associated with the belief that man is an individual created in the image of God and possessing a personal soul. Abnormal behaviour of various types, sometimes undoubtedly the result of mental illness, was during the Middle Ages in Europe frequently attributed to demoniacal possession, and the reactions of society involved religious rites such as prayer, exorcism, and death by fire. In a number of European monasteries, however, there is evidence that mentally ill persons were cared for as sick people, and it would appear that the fate of a mentally ill person at such times who might be branded as a witch or treated as a sick person was often decided by chance factors such as the circumstances surrounding the illness and the particular attitudes of the community concerned. Dissolution of the monasteries in England probably resulted in large numbers of mentally sick people being without refuge and therefore at risk by causing fear amongst their own people. During the centuries that followed, apart from Bethlem, there seems to have been few places of refuge in this country for the mentally sick, and Bethlem itself functioned as a human zoo where visitors paid for the pleasure of viewing the lunatics inside who were chained up and generally in appalling conditions.

During the seventeenth and eighteenth centuries various acts of Parliament were enacted to provide care for the destitute including those mentally ill. The latter were in large numbers confined in Poor Law institutions but they were still regarded with superstitious awe and in no way needing medical attention. Towards the end of the eighteenth century the mental illness of King George III aroused great public interest into the subject of mental disorder and from that

time a number of Royal Commissions investigated the conditions of the mentally ill and made recommendations resulting in a series of Lunacy and Mental Treatment Acts right up to the present day. During the early part of the nineteenth century much legislation, under the guidance of Lord Shaftesbury, enabled and encouraged local authorities to build mental hospitals and the ensuing great era of construction resulted in the Victorian mental hospitals of today. Whilst of great humane benefit, this legislation led to the segregation of the mentally ill from the community. The new mental hospitals were built mainly in the countryside where land was cheap and away from the centres of population. As a result, the treatment of mental illness became separated from that of general medicine in the voluntary hospitals—a cleavage which has only now been effectively undone. The asylum, as the mental hospital was then called, was essentially a retreat where the mentally ill patient could be detained in kindly surroundings away from the public at large. In the early days many such asylums were well provided and did excellent work but with the passage of time most became over-crowded, with resulting vicious circle aggression amongst both patients and staff. This in turn led to measures of restraint such as straight-jackets and padded cells and the fear thus engendered affected not only the patients but also the public at large. The inevitable reaction of the latter became that of resisting committal to an asylum as long as possible and thereafter abandoning the patient as incurable. It is also notable that the Lunacy Acts, which during this period were designed to protect the patient from wrongful certification, tended to exacerbate this public reaction. A further effect of overcrowding was that of so diluting the doctor-patient ratio that medical care, except for a very small proportion of patients, became impossible and this in turn led to a general deterioration of medical standards.

During the latter part of the nineteenth century a great topic of interest amongst psychiatrists related to arguments for and against the use of mechanical restraint for the mentally ill, and after years of erudite battle, legislation was enacted which resulted in the progressive abandonment of such measures. Progress in general pathology was beginning to arouse interest into the organic causation of mental syndromes where at post-mortem these were found to have been associated with demonstrable cerebral pathology. Towards the turn of the century Kraepelin laid the foundations of modern psychiatric nosology by his description of Dementia Praccox and Manic Depressive Psychosis, and at about this time Professor Sigmund Freud was writing his first treatise on psychopathology. Two great psychiatric hospitals were dominating the London scene. In 1915 Henry Maudsley had built a hospital in Camberwell which has his name and has since become the Post-graduate Institute of Psychiatry for London University. The Bethlem Royal Hospital at that time was situated at the Elephant and Castle in the building which is now the Imperial War Museum. In 1930 the present Bethlem Royal Hospital was opened at Beckenham, and it amalgamated with the Maudsley with the commencement of the National Health Service in 1948.

Under-graduate students from the London teaching hospitals attended courses of instruction at the old Bethlem Royal where by that time the standard of medicine and patient care was of a high order. Within the teaching hospitals little or no psychiatry was being taught. At Guy's two well-known physicians in psychological medicine, Dr. G. H. Savage and Dr. Maurice Craig, had both previously been superintendents at the Bethlem Hospital, and as there were no psychiatric patients at Guy's at that time, they would take parties of students to the nearby Bethlem for teaching purposes.

Since the Lunacy Acts prevented the practice of general psychiatry outside the mental hospital, physicians and neurologists interested in the subject began to develop departments for the treatment of the neuroses. Much interest in these disorders had developed from the psycho-analytic theories of Freud and from the existence of neuroses resulting from the First World War, and increasing numbers of patients suffering from such neuroses began to be treated both privately and in the voluntary hospitals. In 1930 the Mental Treatment Act permitted for the first time patients to be admitted to mental hospitals for treatment on a voluntary basis and also allowed the institution of psychiatric out-patient clinics in general hospitals. This legislation, coupled with the new physical methods of treating mental illness, led to a great increase in the proportion of voluntary patients, and at the same time, through the out-patient clinics, a link was established between mental and general hospitals.

The Second World War led to service appointments and training of psychiatrists and clinical psychologists whose interests, apart from treatment, were centred upon factors promoting the selection of recruits and in medical discharge of servicemen who had become unfit due to psychiatric illness. After the war, the veritable host of psychiatrically disabled patients promoted interest into the problems of rehabilitation. Special centres for the diagnosis and treatment of ex-service personnel were established whilst local authorities under statutory orders were obliged to commence the planning of departments responsible for the prevention, care, and after-care, of the mentally ill. The National Health Service Act of 1946 took away the mental hospitals from the local authorities and joined them under the Ministry of Health to the general hospitals. As a result of this act the present tri-partite division of medical care took shape, e.g.:—

Public Health Service.	General Practitioner Service.	Hospital Service.
Mental Welfare Department.	General Practice.	Teaching Hospitals General Hospitals Mental Hospitals

At about this time the Day Hospital movement was gaining momentum in this country. A Day Hospital is designed to provide facilities for diagnosis and treatment to patients who are fit to travel daily from home to hospital. In England the first Psychiatric Day Hospital was opened in 1944 in London and since then the number has rapidly increased to the present time when there is usually to be found one in every psychiatric centre.

In 1959 a new Mental Health Act laid the foundations for the present position of community psychiatric organisation today. This Act repealed all previous mental acts. It enabled psychiatric wards to be established in general hospitals and vice-versa, abolished the magistrate in the certification of mental illness, and established the right of patients to have psychiatric treatment in hospitals as informally as they would for other types of illness. The result of this act has been the rapid development over the past six years of psychiatric departments in general hospitals and indeed, the long return journey of psychiatry to the paths of general medicine was now being achieved.

Society's reaction to mental illness since the second World War has been that of rapid change and acclimatization. This has been due to many factors, and especially dissemination of information about modern treatments of mental disorder in newspaper, cinema, radio, and television. As a result of all this, people have become progressively more tolerant in allowing the mentally ill or disabled to live amongst them. Community schemes involving co-operation between hospital and local authorities began to develop in differing forms and achieved fame in cities such as Amsterdam, Worthing, Nottingham and Oldham. Until very recently the under-graduate and post-graduate teaching hospitals have taken little or no part in district schemes, but as the role of community care for all types of disease gains stature so the training of necessary techniques becomes mandatory for the medical student. This most recent development will be illustrated in our own hospitals in connection with the districts of Bermondsey and Southwark.

Community Psychiatry in Bermondsey and Southwark

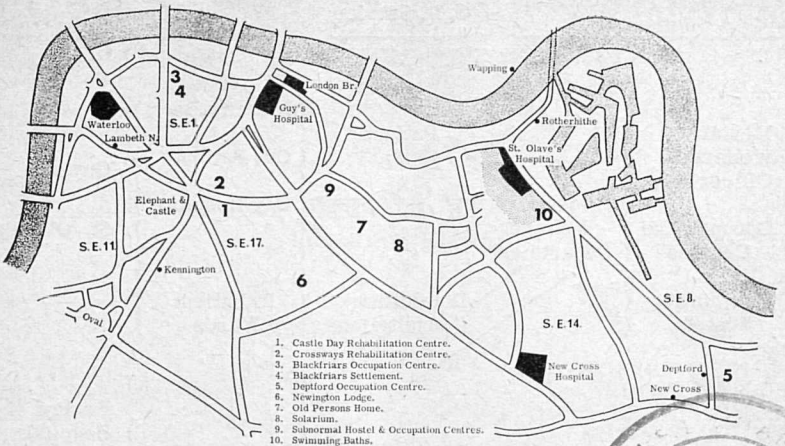
In describing this organisation, frequent reference should be made to the map on page 192. The areas involved embrace the whole of Bermondsey and the adjoining part of Southwark up to the Borough High Street, involving a population of approximately 93,000.

The facilities in this organisation are as follows: —

(i) *Hospital Services.*

(a) Guy's Hospital—Undergraduate Teaching Hospital.
The Department of Psychological Medicine includes the York Clinic with 44 beds and day patients catering for selected patients not necessarily from the district.
Psychiatric Out-Patients in Snowsfields.
The Department of Child Psychiatry.

(b) St. Olave's Hospital—The Bermondsey District General Hospital.
The Department of Psychological Medicine includes 32 male and female beds and a day department of 40 places.
Psychiatric Out-Patients Department.
These services cater predominantly for the district.



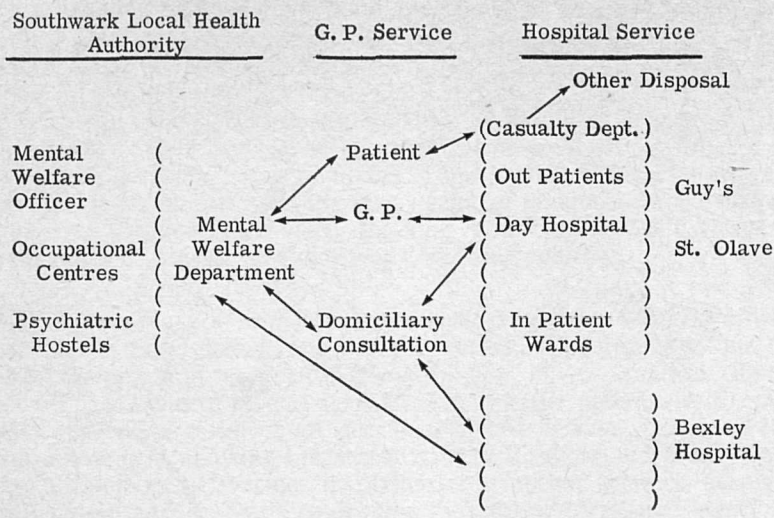
(c) New Cross Hospital—The New Cross General District Hospital.
Specially selected psychiatric patients are treated by Dr. Stafford-Clark in the medical wards but such patients are not necessarily from the district.
The Department of Geriatrics embraces a number of wards providing treatment for geriatric patients including those with simple confusion.

(d) Guy's-Maudsley Neuro-Surgical Unit.
Special unit situated in the Maudsley Hospital and catering for all types of psycho-surgery.

(e) Bexley Hospital.
An adult-psychiatric hospital of 2,000 beds catering for a population of over half-a-million in South East London, including Bermondsey and Southwark. Special facilities include admission units for psycho-geriatric patients, a neurosis female unit, and a male alcoholic unit.

(ii) *The Local Health Authority Services.*
These come under the new Borough of Southwark whose Mental Welfare Department is situated at the Elephant and Castle. (See map.) Under this department four psychiatric centres operate in the district. However, for the future there are plans for a psychiatric hostel and for hostels and sheltered workshops for the sub-normal. Geriatric services comprise a club and hostel in the district.

(iii) *The General Practitioner Service.*
Liaison between general practitioners in the area with the hospital local authority services are mainly by telephone. In a few instances group practices have led to certain general practitioners concentrating on the treatment of psychiatric disorder.



(vi) *Special Psychiatric Services not in the Community.*

Examples of these are: —

(a) Adolescent beds.
(b) Drug addiction beds.
(c) Sub-normal beds.
(d) Criminal psychiatric beds.

The above are situated in special centres, sometimes outside London.

Comment

The clinical organisation of these district facilities has largely been centred at St. Olave's Hospital. This has been made possible by the district Mental Welfare Officers working at the hospital, thus enabling patients easy access to both hospital and local authority facilities. A recent development of the psychiatric emergency service has been the institution of the psychiatric take-in patients from the Casualty Department at Guy's and St. Olave's. This has enabled emergency patients to sleep the night at St. Olave's, where they may continue treatment if domiciled in the district.

The results of this organisation have been encouraging. The great majority of psychiatric patients from the district are now treated as out-patients, day-patients, or in-patients at Guy's and St. Olave's, whilst only a very small number needing longer or special treatment are transferred to Bexley Hospital where they continue to be treated by the same team of psychiatrists. This organisation is possibly unique and will, I hope, be available for study by medical students in the near future.

Community psychiatry represents a division of social medicine. It is concerned with the abnormal behaviour of individuals in the community resulting from mental illness. In this paper I have endeavoured to trace its origins and to illustrate some of its methods in the new organisation of Guy's and St. Olave's.

RESIDENTS' PLAY 1966

BLEEP!

By T. C. DAVIS and J. C. GAZET

PRODUCED BY
BRENDAN HICKS

CAST
in order of appearance

Dr. MacCuddle	ROBERT JOHNSON
Charge Nurse K. Theta	ROGER PARKER
Mr. Kilpitrack	DENNIS SIMLER
Mr. C. Reep (H.S.)	KEVIN STANDAGE
Professor Heavenly Catkins	DAVID BEVAN
Mr. Nils Hackoff	DAVID GOURLEY
Mr. Neville Flabson (Registrar)	MICHAEL VERNON
Dr. Ronnie MacHeaf	TIMOTHY PEET
Mr. Tomkatson	BRUCE RICKETTS
Dr. Gremlinger	JONATHAN ROGERS
Professor Sigy Neversqueeze	ADRIAN EDDLESTON
Mr. Napoleon Lover (The man from G.U.N.C.L.E.)	PADDY WILLIAMS
Dr. Mooston	GARRY HAMBLETON
Professor Yorick	TIMOTHY JENKINSON
Lord Block of Wombledin	WILLIAM LAMB
Herr Tysen	TIMOTHY DAVIS
Mr. Barry Dross (Registrar)	ANDREW WINSKILL
Dr. Stewart Macaroon (Registrar)	STEPHEN GREGSON
Charge Nurses	CHRISTOPHER GACHES GWYN LLEWELLIN CHRISTOPHER LAMB
Stage Manager	JIM BRAMMER
Assistants	CHRISTPHER TOMLINS ADRIAN UPTON ARTHUR MORRIS
Lighting	MAX PEARCE
Sound	ALAN KNELL
Set Design	NEIL WATSON
Costumes	JENNIFER PEARSE ELIZABETH COSGROVE JENNIFER TOWNSEND CHRISTINA LAWRIE JENNIFER CHOWN
Property	PETER WARREN
Special Effects	ADRIAN UPTON ARTHUR MORRIS
Make-up	JENNIFER TOWNSEND JOHN GAZET
House Manager	JOHN OLDER
Business Manager	MURRAY ROBERTS
Publicity and Programmes	STEPHEN GREGSON
Recording	J. HOULGATE
Photographs	B. STEVENSON
Secretarial Help	ROSEMARY EDMUNDS
Evening Dress	S. DA COSTA

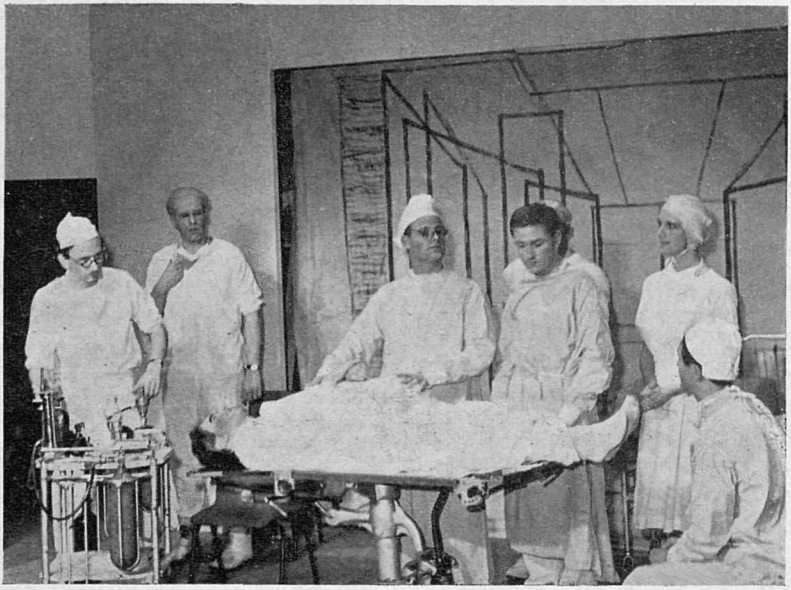
Music composed by
PETER INWARD
Lyrics by

ADRIAN EDDLESTON
BRENDAN HICKS
TIMOTHY PEET
GARRY HAMBLETON
IAN McGILL
KEVIN STANDAGE
BRIAN PICKERING
DRUMMOND RENNIE

At the pianos

PETER INWARD
RAYMOND PIETRONI

Violin
CHRISTOPHER GACHES
Percussion
JACK GIBBS



MacCuddle, Hackoff, Flabson, Catkins, C. Reep, Charge Nurse, Kilpitrack.

SYNOPSIS

A bevy of hairy lovelies, partnered by an H.S. and some familiar figures in the form of Neville Flabson, Barry Dross and Stewart Macaroon, opened the '66 play with much verve. With choreography to match, the chorus ranged in topic from bleeps to B.M.A. and Matron before its leggy exit.

BLEEP! **Registrars and Charge Nurses**

BLEEP! It keeps us on our toes,
BLEEP! When we are in the throes
Of matters frightfully medical, erudite, knowledgeable,
Engaged with affairs personal, even some unmentionable,
BLEEP! Now there again it goes!
No peace, relief or 'scape we know.
As we expound our electronic theme,
As we reveal the terrifying scheme,
We open yet another play
In the now traditional way
And quite obscure exactly what we mean.

BLEEP! So Guy's is in a state,
BLEEP! Behind that face sedate
As epidemic influenza ravages the staff and lends a
Frantic note to all those men-z-admitting nought but what attends you.
BLEEP! Admissions tell you straight
To Guy's they've gone and shut the gate.

As we expound, etc.

BLEEP! There's money in the air,
BLEEP! Alas, it's always there.
The Body will review our pay, the Incomes Board will sit next day,
The Government regret to say . . . and up in arms the B.M.A.
BLEEP! But yet we'll not despair,
Perhaps the railway men might share . . . .

As we expound, etc.

BLEEP! Who's in the daily press?
BLEEP! Who's star of the Express?
Why are our wards so lovable and discipline so malleable?
Why is Guy's fame so durable and nursing here so capable?
BLEEP! Miss Johnson under stress
Explained it all to the Express.

As we expound, etc.

BLEEP! Again we're for the Cup!
BLEEP! Guy's scoring up and up!
The last time Guy's, victorious, left somewhat impecunious
Post nation'lly notorious revels gay and glorious,
BLEEP! But as the day rolls up
It's Guys! Guy's for the Cup!

As we expound, etc.

BLEEP! Lord Robens now's arrived,
BLEEP! Fom fields both dark and wide,
He'll put a forceful point of view, rearrange the baths and loos,
Perhaps close down a ward or two, perhaps declare redundant you,
BLEEP! A Coalussus Guy's astride,
In our new Chairman we'll take pride.

As we expound, etc.

The curtains open onto a spacious theatre in New Guy's House, and the familiar dulcet tones of Mr. MacCuddle are heard talking his patient to sleep. The "patient" is suspiciously protuberant abdominally and rather fully clothed for his situation, could there have been a mistake? But Kilpitrack arrives, trailed by his earnest houseman, Mr. C. Reep, expounding on the dangers of "cracking on in without sorting him out . . . and that". A note of Care is soon struck as Cyril Reep spies the beautiful, buxom (and bold!) Charge Nurse, Kay Theta, but alas, Kilpitrack comes between and takes his H.S. off to scrub up.

Just as MacCuddle turns up the ether, lights another cigarette and is thinking of his next cup of coffee, Professor Heavenly Catkins walks in with Nils Hackoff. The Professor is most concerned that with his heavy commitments ("as you know, I am senior Vice-President") he must leave the theatre at 9.15 a.m. precisely. He leaves to scrub, Hackoff musing on the sheer vandalism of Heavenly's destruction of "their contours". With a large blow into a large handkerchief, a scrubbed Kilpitrack returns, and joins Hackoff in their song.

From Durban or Kimberly or some other mine,
We travelled by Union Castle Line.
We stowed away in a damp, dark hold.
I'm Francis Rankin—I'm Nils Levold.

From Bayswater—From Putney, consultants we are
No—specialists, no—experts, superior by far.
We're the best in the land; I'm in plastics, that's fiddly,
On a bladder or hand; I do prostates and kiddly.

I take a good history and examine X-rays,
Consider the problem, I find that it pays.
I sort it all out, and then crack on in.
It's a hell of a mess, but it helps buy the gin.

Full bosoms I fashion, with nipples erect;
You can't tell the difference or even suspect.
Some others I flatter, according to taste,
If you want a good figure, I'll whittle your waist.

Immigration, immigration, it's not an innovation.
Why did we come at all, was it worth our while?
By Jove it was: we've made our pile.

Chorus.

From N.H.S. in hordes they flee,
No housemen, nowhere, soon there'll be,
Away from the fogs and dear Sister Chrimes,
Gone to the warmth and hopes of other climes.

Kilpitrack finds his patient amid chimes on the cystoscope and disappears behind gowns and legs, before Catkins stumbles in, gowned and bespectacled, vainly attempting to focus on a large amorphous breast. The Professor marvels at the unusual presentation, loin pain and frequency for a week, then he irately remarks on the persistent absence of his registrars. Houseman Reep informs us that not only registrars but even houseman are disappearing, and it can't all be blamed on the West Wing. But Catkins must be off and he instructs Kilpitrack (at the lower end of the patient) to take over; a patiently logical Kilpitrack explains the situation. To complete the confusion the "patient" sits up, still smoking, and reveals that he is Neville Flabson, a surgical registrar, forced to double up as a patient for two operations; not only staff but female patients are disappearing. Hackoff now produces his master-plan—call in Napoleon Lover, the man from G.U.N.C.L.E.—"he is so good, he will get to the bottom of this!"

In the second scene the plot shifts to that mysterious St. Olave's, tonight reeking of conspiracy. Ronnie MacHeaf is reassuring Tomkatson that "Enuresis is a charming little foible . . . some people never grow out of it", as they wait for the unknown "Big Mother" who invited them to announce herself. While MacHeaf tickles a somewhat battered baby and the other looks gloomily on, a so-called phallic symbol enters, and Gremlinger is revealed. The villain has arrived. Gremlinger has realised that the real power behind Guy's is not Lord Rowbones, not Lady Bo, but the invincible Herr Tysen

from the Superintendent's Office. This is the man who can bring all three of them to power. By ostensibly altering the communications system, Gremlinger now controls housemen, registrars and consultants; there are dire penalties for failure to comply—poor MacHeaf was denied golf for three weeks as he was late doing Sneard's O.P.D. But to add respectability, another has been blackmailed to join them, his slides are in Gremlinger's hands. A powerless, but nevertheless vigorous Sigy Neversqueeze makes his entry.

SIGY SONG **Sigy**

I'm never alone with a cigarette,
I huff and puff all day.
My ebony holder keeps the fags quite dry,
My beard is a good ashtray.
I see no patients, just bits of them
Which I slice in my microtome,
Those wonderful, magnified cells I see,
From muscle, nerve and bone.

Grizzly specimen with grizzly beard,
On carcinomatous meat he's reared,
His frozen sections are stained with beer,
He's our, dear old, Sigy.

I used to own a Lancia,
And drive around in state.
But now I've bought a swish new car,
That's really up to date.
It's very smooth and shining bright,
A technological feat.
The only feature I hardly used,
Is the fully reclining seat.

Grizzly specimen, etc.

I command esteem in my special field,
To the Surgeons I'm a friend,
My specialised knowledge is always there,
On that you can depend.
I work quite hard, all through the day,
I'm nearly always here till three.
Your frozen sections I'll certainly do,
If they arrive before tea.

Grizzly specimen, etc.

I'm ever so proud of my nuclear power,
You may say I'm a king.
Mitotic figures I hunt with glee,
I never miss a thing.
And if you see me sitting, in a trance-like state,
Euphoric but at ease,
You'll know I've just heard my brand new name,
PROFESSOR NEVERSQUEEZE.

Grizzly specimen, etc.

Gremlinger explains to the conspirators how the registrars are being slowly removed, and to demonstrate his power over them he summonses them in spirit, in semi-darkness and in whiffs of mist. Dross is relegated to the diabetic clinic once every blue moon, Macaroon appointed head gardener to Professor Blunderbuss, and Flabson left with clinics and duties galore, besides the added duty of acting as a patient when required. The co-conspirators are suitably impressed, but their confidence is shaken when a dashing young surgeon, Napoleon Lover, the man from etc., suddenly appears from where he has been hiding and rides through them on a Moulton—"I know your plan and it won't work!" Is Guy's to be saved?

The answer does not come at once, as we are transported in the next scene to the romantic pastures of Theatres' Staff Room, where Cyril Reep, Kay Theta and another blond and winsome charge nurse are having a coffee and a cigarette. Kay is induced to mimic Sister Claws, with several references to Sister Bord's horse, and then the girls (and their voices literally) break into song. When this becomes a concerto for euphonium and violin we know there is nothing our nurses will not do.

CHARGE NURSES' SONG

They call her Sister Claws
To us she is the chief,
She lays down all the laws
Much to the Houseman's grief.
Of course, she really loves it, to
Admit it she is lief.

We've got the shift at Guy's,
We call them A, B, C.
They may not really work
But we have more time free
We don't know how to spend it—
We need more £ s. d.!!

Matron needs a bleep
To call her to the ward.
I'm sure she wouldn't hear
But that's not untoward,
She only goes there once a year
The time she can't afford.

The tower block is postponed
Till 1984.
The nurses' home is being rebuilt
To take four nurses more,
The pile of rubble in the park
May well conceal four more!

This idyllic peace is disturbed by the entry of the surgeons, Napoleon Lover in the lead (of course). Catkins has realised that the situation is indeed serious, having "almost made a faux pas myself today", and even Sam Hoss has done more than his customary one case; obviously they are all working harder. Lover exposes the St. Olave's plot, headed as it is by a psychiatrist, obstetrician and paediatrician ("sounds like Lord Silkin's Bill in action . . ."). The evil trio are somehow controlling and removing the junior staff, and through them are transferring all the Victoria patients to St. Olave's, where Tomkatson can have the deliveries—he needs 30 to be a Professor—and MacHeaf can play with all the babies. The surgical patients are being used to fill the beds in Victoria. Lover has, again, saved the day.

NAPOLEON'S SOLO **Mr. Napoleon Lover**

Master of Woldingham, Old Chromic in hand,
In Nuffield my studio, the masterpiece lies
Incision, sfumato and cautery bland
Gallipot, Tempera, Cetrimide, Size.
My life's in perspective, the surgical norm,
With mere tactile values there's no room for greed.
While George Scott can study Significant Form,
To the Vanishing Point money worries recede.

You've reached the top,
But why should you stop.
The higher you climb, the softer the drop.
Napol', Napol', you're top pop of the Op.

Totting up Blue Chips, dreaming of murals
Op Art's exponent, I clamp the saphenous.
Muse on my patient's Rubensian surals:
Each lumpy incompetent-valvular Venus.
Taking a course at the Barbizon School
Costs money to any realistic aesthete
But I've learnt to love (for I am not fool)
The beauty of faintly oedematous feet.

You've reached the top, etc.

Collected and calm in each frank Tate á Tate
My clinical notes are queer ciphered graffiti
Sotheby's; Christie's; Furniture; Plate.
Be-Louvred, Uffizied, and worthy of Pitti.
While Baker is lost in matters acoustic
And others waste time in a suturing Bosch-up
I calmly wash bonds and profess I'm Agnewstic;
Sit watching the box at my Woldingham nosch-up.

You've reached the top, etc.

Ulnar or carpal, gastric or glandular
Turn my artistic brain to each task.
Animula outwardly vagula, blandula;
Sharp as a palette-knife behind the mask.
Scanning the auctions, I fish Braquish pools,
Pick up the Stubbs and look at the Hals.
Idle down Bond Street, buy up the schools,
And watch my investments grown on my walls.

You've reached the top, etc.

Our heroes decide that they will take the matter to their Scottish colleague in the School. An admiring H.S. and a cooing charge nurse wonder how anyone, except for Lover, could have sorted out the plot by Act I, Scene 3. Act II sees the return of the chorus line, dance routine and all, with an intermezzo of musical hearsay, completely irrelevant to the plot but none the less pertinent.

VITIS VINIFERA

Officially we correspond by 'phone or to's and fro's
But if you want to keep attuned then everybody knows
You should use the Grapevine, for its democratic ear
Hears, long before it has been said, just what you want to hear:

Anaesthetic chiefs are quite elusive you will find
You'll have to search the gadget shops to unearth Alan Hind
No one's found out yet exactly where to look for Hall,
Potty's a full-timer—so he's never here at all.

The Honourable David in a gentlemanly way,
And Mike Hutton, too, will tell you that they've had a frightful day;
One goes off to Yorkers to give dope for E.C.T.
The other mooches off to have a cup of tea.

Michael Joseph's on at Brompton and we cannot fathom why
For he cannot tell the difference twixt a, v, x, and y,
But better folk than us have thought, or thought they slightly think
That perhaps—or maybe there again—oh, tell me what you think.

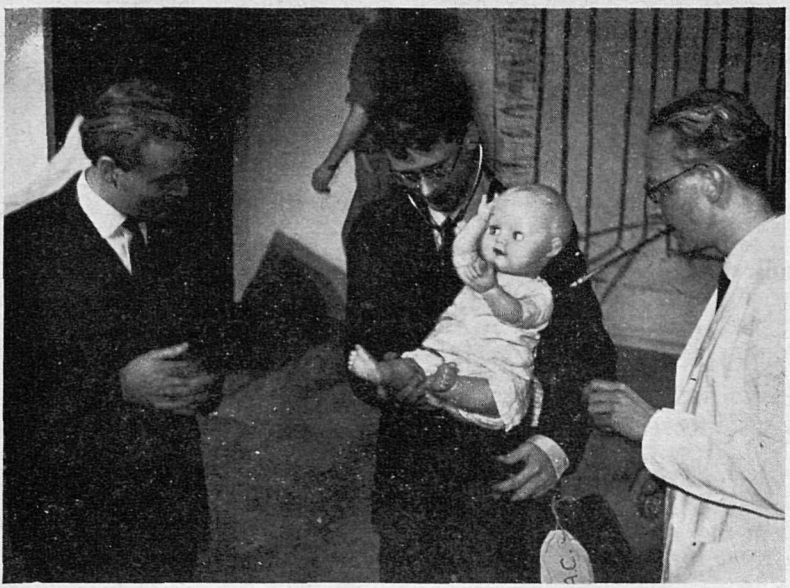
Jack Joseph finds life difficult and doesn't understand
That his native Scottish humour isn't like our local brand;
His feet were on the ground, but now his head is in the air—
Is it because he studies posture that they've given him a Chair?

The Grapevine has its uses for it tells us all the news;
Though it's open to abuses, we believe the bits we choose.
We cannot guarantee that what it says is always true
So what you believe this evening is entirely up to you.

There's a rumour that Tom Lewis is about to get a chair—
And all the beds as well as all the patients in his care;
Gib. is soon retiring, so he won't stand in the way—
But we wonder what the Johns of this establishment will say?

They're looking for a Dental Dean's Assistant-with-a-view,
But whoever they appoint the choice will not be up to you;
For though Fred Warner's getting on and doesn't seem to care
It will probably turn out to be a family affair.

The Grapevine has its uses for it tells us all the news;
Though it's open to abuses, we believe the bits we choose.
We cannot guarantee that what it says is always true
So what you believe this evening is entirely up to you.



Gremlinger, MacHeaf, Neversqueeze

Sister Laws we're told, is leaving, but we're told this every year—
Like her views on operating "it will never happen here".
But if motherless we found ourselves we might get something done—
For then to whom would all the other Theatre Sisters run?

Out-Patient Clinics cause concern—they overrun their times
And everything's disorganized, apart from Doris Chrimes;
She herds the patients off for tea until it's time to go—
And then she brings them back again and says that you've been slow.

Is it something from Havana that is turning John Dow green?
Or does Cheltenham project a brighter image on the screen?
While Dow is in the basement, emitting clouds of smoke,
Saxton's in the attic giving ventricles a poke.

By just a few physicians some Intensive Care is planned—
But if you've ever seen Cornelius then you will understand
That' in spite of all the wires and tubes and trimmings on the wall,
If a patient does recover then he wasn't ill at all.

Officially we correspond by 'phone or to's and fro's
But if you want to keep attuned then everybody knows
You should use the Grapevine, for its democratic ear
Hears, long before it has been said, just what you want to hear:

The second act proper opens in the Dean's Office, to strains strangely reminiscent of Andy Stewart, and Dr. Mooston takes centre stage. Lord Block and Professor Yorick can scarcely contain their astonishment when the Highland Fling is, in dignified manner, flung :

OH, DR. MOOSTON **Dr. Mooston**

In the house of Thomas Guy,
Wearing smartest Dean's brocade
Doctor Mooston rules the roost,
And also plies his mortal trade.
All the patients in his practice,
Whether ill or just in need.
Will agree with you and me that Doctor Mooston will succeed.

I'm Doctor Mooston—surely you have seen:
I'm without a doubt, let's shout it out,
The finest Guy's new Dean;
I travel far in my Rover car,
And patients always know
They needn't worry further when they Hear that "Well, hallo!"

At the weekly Asthma Clinic,
There I am with stethoscope,
Reviewing rales and rhonchi,
Giving out dilator dope;
With the wheezes, and the hacking,
Fresh Haemoptysis—for them
It really isn't funny to have a dose of Scottish phlegm!

I'm Doctor Mooston, etc.

I'm the idol of the nurses,
To my Housemen I'm a king.
Especially with the sisters,
Greying temples are the thing.
All the ward clerks on my firm
Really dig the highland lilt
And always love to see me when I'm Reeling in my kilt!

I'm Doctor Mooston, etc.

Now every student's bible
Is a book in brightest green—
It's the envy of the man
Who writes prescriptions for the Queen.
All the authors of the volume
Ancient medicine do denounce:
Practitioners of the latest: Doctors Mooston,
Groiner, and Bounce!

I'm Doctor Mooston, etc.

When the Scottish sound has subsided, Mooston, Block and Yorick attempt to discuss, with little success, the junior staff crisis. Mooston suspect a revolt led by Herr Tysen, who has already threatened to shave his head if he doesn't answer his bleep more quickly. Lord Block is puzzled—"Oh-o-oh. What is a bleep, doctor? . . . Does it fire extra-systolic ejection blasts? We must know". After a graphic demonstration by Yorick of the bleep sound, enter Catkins and Hackoff, full of their discoveries. The villains are named and their plan recounted. Block is appalled "nay, dismayed, that in this year of grace nineteen hundred and sixty-six this miserable plot should be uncovered".

WHATEVER HAPPENED TO BABY R.C.B.? **Lord Block**

When I was a baby R.C.B.
I was a timid little thing on my mother's knee.

Just look at him now, how could this be?
Whatever happened to baby R.C.B.?

I grew up to R.C.B.
A student in medicine and surgery.
With medals in both, it's plain to see
Why the other guys at Guy's were jealous of me.

Just look, etc.

Very soon I was known as Mr. R.C.B.
And having strolled through the terrors of the F.R.C.
I sorted out the branches of the bronchial tree.
What a bore! So I tried valvotomy.
Then the tetralogy and A.S.D.
I was going to the top meteorically.

Just look, etc.

So the Queen made me Sir R.C.B.
Put her sword on my subclavian artery.
I became the hospital's V.I.P.
And got promotion to the P.R.C.
There was nothing now that could stop me—
Everything was going so marvellously;
Even the outlook was heavenly,
For if angels have hearts they'll need me!

Just look, etc.

So here I am, Lord R.C.B.
Right at the top of the hierarchy.
A peer of the realm, as strong as can be.
In the College of Surgeons, W.C.
Two. What is there left in life for me?
I suppose I could work on my oratory.
Home rule for Wimbledon? I can just see me
As King of that little principality.
Or perhaps I should look across the sea,
If Mr. Smith can do it, there is hope for me.

Just look, etc.

Hackoff demands action, and tells how Napoleon Lover has been tailing the plotters all over South London. They must surprise them in their lair. Then the bleep sounds—Lover awaits them in the labour ward. When we arrive in the labour ward we find Kay waiting for Cyril, and it is not just the fate of the hospital at stake here. Kay plays a little stand-offish at first, but C. Reep's rugged good looks, natural charm, and white coat eventually win her over. They sing passionately of their burning love, a note of sadness intruding. . . .

PASSIONATE DUET **Cyril and Kay**

Both: We first exchanged glances over masks in the theatres.
C: I was a dresser.
K: And I was a stripe.
Both: Life has been tough on two ardent lovers.
C: But I'll soon be a surgeon.
K: And I'll be your wife.

Our elders and betters may laugh at our love
But our blood is on fire as we kiss and embrace.
Don't forget that we work, and you take the credit,
Give us time for our love, give us time and a place.

K: Students are common, they're two for a penny
C: And second year nurses, they come by the score,
C: But now I'm a Houseman my value has trebled.
K: I'm getting a ring, a girl couldn't want more.

Our elders and betters, etc.

K: Lovelorn looks over coffee on night rounds.
C: Your figure improves in a tight theatre dress.
K: The masterful way in which you cut stitches.
C: The elegant way you mop up the mess.

Our elders and betters, etc.

K: Passion is hard, and life is so wearing.
C: On eight quid a week, and food in the spit.
K: The door has been locked between East Wing and West Wing.
C: I've had a key cut, but the damn thing won't fit.

Our elders and betters, etc.

Passion is abruptly curtailed with the arrival of Gremlinger, followed by Neversqueeze and Tomkatson pushing a very second-hand Victoria patient, surprisingly robust and familiar, on a trolley. Another for St. Olave's we gather, as MacHeaf roars up in his Mini-bus outside the window. There is a spot of bother fitting the patient through the window until Tomkatson points out that it will have to be a breech. Sigy's groin hook is scorned, and delivery is eventually accomplished, with success. They leave, after . . .

GREMLINGER'S SONG **Dr. Gremlinger**

At George's where my story starts they cannot hide their broken hearts,
An intellectual loss they have sustained.
I combine psychotherapy with music and philosophy
Until true peace of mind has been regained.

So not for him your E.C.T., nor drugs to soothe anxiety
Pavlovian psychiatry will lead us on to victory.

I love to psycho-analyse, material abounds at Guy's;
Power complexes disrupt your common sense.
A touch of subnormality, frustration, sensuality—
It really is no wonder you're so tense.

So not for him, etc.

I'm really keen to hypnotise, I fix them with my big brown eyes
And off to sleep they go without a sound.
I'm deconditioning Gerry Vaughan's phobia of leprechauns
And helping Trounce relax before his round.

So not for him, etc.

Oh! What can beat the satisfaction I get from ether abreaction?
Students wait with baited breath, it seems.
If in the tension I should let the patient have a cigarette
The spectacle exceeds their wildest dreams.

So not for him, etc.

When day is done I lie in bed and pull the covers round my head
No Ekbom legs to stop me sleeping sound.
(I keep my light on now and then for fear of ghosts and Muffler Men,
And gnomes with torticolis prancing round.)

So not for him, etc.

When I have gained the highest seat—my colleagues prostrate at my feet,
I'm sure I'll still avoid the public scene.
My subtle wit—not clear to see—would not sound right on B.B.C.
But I would make a fine, paternal, Dene.

Cyril and Kay are amazed—"No sooner are the patients admitted . . . than they are out? . . . Reminds me of Sister Jarvis in one of her on days". Lover sweeps in, followed by his colleagues, and directs the action to the site of the bleep control centre, Nuffield House. There we find Gremlinger showing a heavily curtained limited room to a mystified MacHeaf and Tomkatson, mystified until Gremlinger pulls a switch to reveal a large machine, flickering with lights and dials and screens. As Gremlinger says, "A grand doll of a computer—I call her Mandy . . .", enabling him to follow or control

any consultant he wishes. He is about to further demonstrate the machine when—dramatically—he is silenced by the entry of Herr Tysen, in dark shirt and jackboots, accent to the fore. A tyrannical Tysen barks that he, in fact, controls Gremlinger, Bleep Control and the Hospital; the final victory for bureaucracy is near.

THE POWER SONG **Herr Tysen**

For the good of the State I run the show
Man of office whose in the know;
But I have found that it's so slow
If medical men have their go.
For efficiency's sake I must rule,
For, you see, I am no fool.
The ghoulish noise shall be my tool,
Of bid for power, mean and cruel.

The bleeps shall be
By my decree:
I must have power!

For the Tysen cause I must lead
Doctors, nurses—they must take heed
Of my driving lust, my deathly creed.
My wish for status, my urgent greed,
For the patient's fate I care nil;
Tysen, the power!

Housemen's views I note less still;
Consultants even shall neither kill
Nor assuage my onward will.

The bleeps shall be
By my decree:
I must have power!

For the sake of Guy's I give myself:
All my might and all my stealth
Shall be employed to discard health—
And turn Guy's name into wealth.
For history's tale I shall scheme
In secret light; and with my team,
I shall drive on to forge that dream.
So shall our names mean esteem.

The bleeps shall be
By my decree—

Further plotting is halted by the sound of the surgeons approaching, and the plotters hide. The machine cannot be concealed, however, and Lover recognises it for what it is. Gremlinger, Tomkatson and MacHeaf show themselves, but the surgeons will hear of no compromise. The villains are overpowered, the machine unlocked, there to reveal registrars pedalling at their wheels to keep the machine going, under Tysen's fierce lash. Faster and faster they go until Flabson screams "Shoot Tysen". Lover has the gun ready, and registrars, hospital—and Lover—are saved.

FINALE **Company**

The bureaucrats are finished now,
The plot is now unfolded
And Tysen dies his doleful death,
Our heroes are ennobled,
The villains all exposed and down,
On scales both just and social.
The tale has managed to resolve
All problems broad and local.

And Guy's has won!
And Guy's has won!
That place by the Miller
With the Park and tradition of
Wilks and Bright
And the Play tonight
and the rugger each year
and tears for the past
and towers to come
—off a street in S.E.1.
—has won!

The play is almost finished now,
Our satire now is ended,
And dignities will be resumed
Pedestals reascended.
The players' parts will be reversed,
And parts so grand this day,
The actors will relinquish soon
To those out there who say

And Guy's has won! etc.

This song is almost finished now,
Our message is completed.
We hope you note our gentle fun
Was not of pride depleted.
Our characature and anti-pomp
Is a right we shall not shun
But nevertheless we present the men
Who keep Guy's in place One.

And Guy's has won! etc.

CRITICISM

Looking back on this year's Residents' Play revives many pleasant memories and raises one or two questions.

It was a traditional play, with all the trappings, a success. Let's start with the sets—as one observer commented to me—"they were well up to standard". Of course, Residents' Plays must have their exotic pseudo-scientific and medico-fantastical major set, and the Bleep Centre, with its electronic flashes driven by sweating registrars, Neville Flabson, Stewart Macaroon and Barry Dross, on bicycle ergometers under the Fascist Lashes administered by the Paw of Power, was in the very best traditions. And what a nice touch to site it in Nuffield House!

Then the music. I always swell with Guy's reflected glory when I take outsiders to the Play: "what a credit to your selection procedure that you can find such talented composers and instrumentalists among your young graduates", etc. etc. Well, this year didn't let me down. From the piano's overture to the closing chorus, the tunes and rhythms ranged over the spectrum of Musicals. And when we were offered a solo on the euphonium, rightly to tremendous cheers and deserved encores. There is absolutely no doubt that the proper introduction of individual talents on the Junior Staff raises important questions about the future of the Play—should it be turned into a review—perhaps put on in the summer? May is the month when the Registrar General's Office do the Census, because there is least absence from work from sickness and fewest people are away on holiday. Perhaps this means that we should put the Play on then, too, when there is least pressure for medical care, and fewest consultants in for their "come-uppings" can sidle off to ski or swim to avoid the awful truth.

The plot? One might complain that it hit out at a hospital feature that couldn't hit back—the personnel executing the deliberations of all those sub-committees of committees responsible to the Governing Body. One might complain that while it was complex, in a weird way it wasn't bolstered up by a sufficiently forceful subplot. And one might admonish Davis and Gazet for not having more romance, not that they didn't pay lip-service to sex, but for me anyway there wasn't enough of the student/junior staff-nurse relationship which ends in marriage and birth notices in the end of the *Gazette*. In these days of the 42-hour week and shifts, with nurses at other hospitals doing part-time jobs in department stores and cafes, there is the risk of less and less, not more and more student/nurse love. I suppose I'm just a sentimental old man, nostalgic about the days when nurses were kept busy within the hospital, not "up West" with West End men.

But most important of all in the Residents' Play—the impersonations—several live on, really memorable for me. Garry Hambleton as Dr. Mooston, a handsome, lithe, gallant-kilted Scott, rolling his "r's ", dancing his Highland Fling, beautifully ruffled and reminiscent of someone advertising some sort of special Liqueur Scotch. Timothy Peet as Dr. Ronald MacHeaf, button-holed, vague, open-mouthed,

with papers stuffed in his pockets, spectacles tumbling down the bridge of his nose, but pungent, acute comments coming from his lips. Adrian Eddlestone as Professor Neversqueeze—rather over-caricatured perhaps, but wonderfully gestured, with everything as it should be in the territory of the superior vena cava, head on one side, shoulders moving, hands expressive and expansive—well done! Finally, William Lamb as Lord Block—what a pity his Lordship couldn't see this production if only to recognise once again the affection that is felt for him, and what a wonderful song—probably he, too, would have wondered "Whatever happened to R.C.B.!" But even the coronet didn't hide the paroxysms of blinks.

But I'm rambling on, relishing all those other performances: Dennis Simler as Mr. Kilpitrack, David Bevan as Professor Catkins, David Gourley as Mr. Hackoff, Paddy Williams as Mr. Lover—(a *very* surgical play I hear you say!), Timothy Jenkinson as Professor Yorick. The others will forgive me for not itemizing here their care in hunting down their adversary and showing him himself. It's vital, of course, that this play, this mirror, be produced each year and held up for the Establishment to see itself, and gasp: thank you, Mr. President of the Residents, for your piano playing and for keeping to the traditions and doing it so well again. And may we now hear from others whether the winter *is* the best time for such a festival.

W. J. H. BUTTERFIELD.

NOTICES

The Pupils' Physical Society

THE BEDDARD AND LAIDLAW PRIZES.

This year the committee of the Society decided that it would be wiser to discontinue the practice of holding the competition for these prizes on one and the same evening as the process was becoming somewhat of a mental marathon.

As a result of this decision the Laidlaw prize was held first at 5.0 p.m. on March 24th. Some thirty members of the society attended an interesting evening to hear four highly specialized papers on very diverse topics of Medical Science. The evening was begun by Mr. Michael French with a paper on "The Prevention of Graft Rejection". An experimental approach using specialized anti-mouse leukaemia immunoglobins. Next, Mr. Jacques Domaingue gave a paper on " Biochemical Lesions in Congenital Erythropoietic Porphyria and Acute Intermittent Porphyria". He was followed by Mr. Richard Hughes with a paper on " The Pathology of the Stretch Reflex". Finally, the evening was rounded off by Mr. David Tong with a paper on An Hypothesis of Regional Vascular Specificity. "A Concept of Certain Hypersensitivity Reactions and Immune Disorders based on a proposed regional variation of the Vascular Endothelium in the form of an Antigenic Mosaic".

All the speakers found that fitting their ideas into the twenty minutes allowed for the papers was a difficult task, notwithstanding this, the evenly high quality of the work was very impressive indeed. Dr. Lunn and Dr. Stewart Cameron, who had kindly given time to judge the event, finally awarded the Laidlaw Prize to Mr. Michael French, who had himself done some of the research work upon which his paper was based.

The Beddard Prize was not held until April 4th, coinciding with the centenary of Thomas Hodgkin. There were five entrants for this competition for the best case history, and the evening began in slight confusion when, owing to an error in organisation, some fifty dentists crowded into the meeting before it moved to the calmer waters of the Surgical Demonstration Room.

The evening was begun by Mr. Richard Hughes, who presented " A case of chronic lymphatic leukaemia with lymphosarcoma cells in the peripheral blood which presented as skin tumours". Next came Mr. David Masters with " A complicated case of renal hypertension". Then Mr. John Stevens, with " A case of clostridium welchii infection and renal failure complicating abortion". He was followed by Mr. Michael D'Souza, who presented " A case of painful phantom limbs". Finally, Mr. Marcus Pembrey concluded the evening with " A case of gradual recovery and adaptation following cardiac infarction".

In general, the speakers found the time limit less exacting than in the Laidlaw prize; however, the papers were not of such a uniformly high quality as in the latter competition. The judging was kindly performed by Dr. Rennie and Dr. Knight, who awarded the Beddard Prize to Mr. Richard Hughes for a paper of all-round excellence.

Hockey Club A.G.M. and Dinner

The Hockey Club A.G.M. will be held in the East Wing at 6.0 p.m. on Friday, 27th of May.

The Annual Dinner will take place the same evening, at "The Horseshoe", Tottenham Court Road, at 7.30 p.m. for 8.0 p.m.

All past and present members of the Guy's Hockey Club are welcome. Tickets cost 27s. 6d. each. Anyone who is interested can write to the Captain of Hockey, c/o East Wing.

C. A. BINKS.

Alumni Luncheon

The usual Alumni Luncheon will be held during the Annual B.D.A. Conference in Scarborough, June 13th—17th. Anyone wishing to attend should contact G. Brocas Hunter, 20, Ramshill Road, Scarborough.

Music Circle

The next meeting will be on Tuesday, 19th April, at 8 p.m. Michael Coe will present " The Concerto—from Bach to Bartok".

SPORT

As winter turns to spring one's thoughts turn to another season of cricket, tennis and athletics. But at this time Guy's can look back on a very successful winter, winning the rugby and football Cups.

The 1st XV finished their season on April 2nd with their game against Old Whitgiftians, one of Guy's bogey sides of recent seasons. The game was rather disappointing with Guy's again failing to lay the bogey by losing 3—6. Unfortunately, John Davies, in possibly his last game for Guy's, limped of with a knee injury. Guy's won more games than they lost this season, for the first time for years. This is hardly surprising because Guy's have played better and more entertaining rugby than they have done for years—the final climax being the Cup win over St. Thomas's.

Thorburn, having recently become a Barbarian on their Easter tour of South Wales, has been picked to play for a London XV against a Paris XV in Paris on April 17th. The "A" XV toured North Wales over Easter, playing Llandudno and Bangor. A full report will follow in the next issue.

The end of the rugger season is highlighted by the various sevens tournaments. Guy's have been invited as a guest side to the Ayrshire sevens on April 16th. The following week are the preliminary rounds of the Middlesex sevens at Sunbury, with the finals at Twickenham on April 30th.

The hockey teams paid their usual Easter visits to the Folkestone and Paignton festivals, which were again great successes and fitting climaxes to a season of mixed fortunes. The 1st XI lost to Bart's early in their cup competition, whilst the 2nd XI had better fortunes by drawing in their final, hence becoming joint champions with St. Thomas's.

As far as summer sports are concerned first prospects regarding more cup wins in tennis, athletics and cricket, are vey good. Guy's hold the athletics and tennis championships and should retain the same. Last cricket season was one of rebuilding, and we must hope that lessons learnt will help Guy's to regain the cup they held for so long only a couple of years ago.

RUGBY FOOTBALL

GUY'S v. OLD WHITGIFTIANS

At H.O.P. April 2nd, 1966

Result: lost 3—6

For the last game of the season, Guy's were forced to make six changes from their Cup-winning side. When one of the reserves failed to turn up, Mr. Tom Lewis—one of the Club's vice-presidents—stepped in to fill the gap. His performance made it hard to believe that it was his first game for five years.

The match was a typically scrappy end-of-season game. Neither pack seemed particularly interested in gaining possession from the loose, and the backs showed little in the way of constructive play.

In the set-pieces, they won the hooking duel 4—1; but this advantage was nullified by the fact that the Guy's pack were out-shoved throughout. In these circumstances it was strange that the Guy's No. 8 should persist in acting as an extra scrum-half from the set-scrums, where his weight was badly needed. The line-outs were indecisive in the first quarter, but Kingdon and Cockburn eventually gained some measure of control in this department.

Many penalties were awarded for line-out infringements, and Elliott, for Guy's, and the Whitgiftian kicker were each successful once in their goal-kicking attempts. The other score came from the Whitgiftian fly-half who dropped a fine goal when surrounded by Guy's defenders.

Of the Guy's players, Lewis fielded and kicked well throughout; Thomas and Egwuatu ran hard, and the latter played a particularly fine game in defence, and Edgar, at fly-half, played a good first half. Of the forwards, only Sharp played with his customary speed and vigour.

Five minutes before the end of the game, John Davies had to go off with an injured knee. It was sad to see him end the season as a spectator. All-in-all, it was a rather disappointing end to an otherwise memorable season.

J. H. W. DAVIES

Guy's team: T. L. T. Lewis; E. Egwuatu, R. J. Beacham, D. Elliott, G. Thomas; J. A. Edgar, P. G. F. Swift; A. Forbes, G. Hey, J. E. Davies (capt.), A. J. Kingdon, M. Cockburn, H. C. Sharp, D. J. Hendrick, K. Brown.

FOOTBALL

United Hospitals' Football Association Cup Final

GUY'S 2, THE LONDON 1

(after Extra Time)

The match kicked off with Guy's, playing with a stiff wind, losing the ball straight away. The early play by both sides was scrappy with players unable to control the ball and misjudging the bounce. More than one Guy's player looked out of position, which, indeed, they were. The London gained early mid-field superiority which their forwards made no use of.

After 20 minutes, Elias and Powell-Jackson, who both had very fine games, forced the London goalkeeper into a good save when a lob was deflected by a defender. Two minutes later the best move of the match, so far, ended with Anto's header grazing the crossbar. At this point the London had their only bad luck of the afternoon when their centre-half, Smith, broke his leg when trying to turn for a ball.

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When play restarted Guy's went near on several occasions, especially one attempt from Elias. But the first half still resulted level with the London not seeming to be one man short.

The second half began with the London using the favourable wind to float long balls high across the goalmouth. The Guy's defence looked very shaky, and this was confirmed after ten minutes and an incredible decision by the referee. A free kick was awarded to the London after their left-wing had skilfully controlled the ball with both hands, just prior to being tackled. Lindridge was lost in a ruck of players going up for the cross and the London were one up

From the restart Guy's went all out, but their efforts were fruitless, due to a lack of co-ordination among the forwards. Then suddenly a centre from the left was plopped against the post. The goalkeeper, with all the time in the world to clear, failed to do so, and Ward forced the ball home after wriggling past several defenders. Both teams went flat out now to prevent extra time but to no avail, although Poole scored the best goal of the afternoon with a good movement from the half-way line, only to find it disallowed for another Guy's forward standing offside.

During the first period of extra time, the Guy's forwards kept up an incessant barrage on the London goal, prompted by Elias, Poole and Powell-Jackson. From one of these the latter scored. All the players by this time were very tired, tackles were becoming more than robust and many had cramp. After the change round the London threw all their players, except the goalkeeper, into attack. The Guy's defence held on admirably, with Nash the outstanding player. Lindridge held everything that came his way, and Guy's had won the Cup.

At the beginning of the season this result would have seemed unbelievable. The fact that it happened is a triumph for Elias who has produced a great team spirit from what is not, perhaps, the best Hospitals side this year.

Team: D. Lindridge; R. Davy, W. Brander; S. Poole, I. Nash, R. Lovell; M. Anto, J. Powell-Jackson, D. Ward, E. Elias, D. Jacobs.

R. G. PINKHAM

HOCKEY

UNITED HOSPITALS' 6-a-Side COMPETITION

At Cobham. Sunday 3rd April, 1966

Although seriously depleted by pre-clinical holidays, a wedding and other less plausible excuses, the Club turned out two teams for this competition. It was a cold, cloudy day, and one of mixed fortunes.

Guy's II came up against some stiff opposition and failed to win a match. However, they ran some of the teams quite close and were beaten as much by bad luck as anything else.

Guy's I started badly by coming up against Thomas's I and losing a close, exciting game 1—0. However, they managed to win their two remaining matches against Bart's II and U.C.H. II, 1—0 and 3—0 respectively. No one Guy's player was outstanding in any of the games, but it is a measure of their team's superiority in the last match that the kicking-back only touched the ball three times.

Unhappily, Guy's I did not reach the semi-final as a result of goal-average and short corners.

The two teams from Thomas's met in the final and their second team won. By this time both Guy's teams had become firmly ensconced in the bar to avoid the elements.

Teams:

Guy's I: S. Worthington; J. Crafts, N. Turfitt; S. Cripps, D, Steer, R. Carruthers (capt.).

Guy's II: S. Rear; M. Sutton, C. Calder; A. Brooks, P. Kirby, P. Bundred.

S. WORTHINGTON

BOXING CLUB

GUY'S v. LYNN A.C. and FITZROY B.C.

In Pavy Gym. Tuesday, March 22nd, 1966
Result: Guy's won 6—1

Guy's, fighting a combined Lynn A.C. and Fitzroy B.C. team, in place of Sandhurst and University of London B.C., won a decisive victory in their last tournament of the season.

It has been suggested that the future of boxing is in the balance at present; in view of this, the result is more significant, for whilst Gibson, Edgar and Hughes, after years of valuable service to the Club, were fighting for the last time at Guy's, Davidson and Marsh were making their debut; all five won their bouts, an encouragement for the future.

Gibson's better footwork and countering enabled him to get the better of Jones (Lynn B.C.) after a quiet opening. In the final round the fight came to life: Gibson, boxing skilfully, scored often with his left to win a clear victory.

Despite being caught in a corner twice early on, Hughes evaded his opponent well, scoring equally until the final round, when he got slightly on top to land some good punches and a narrow points decision.

In the first round of his fight, Davidson, whose boxing belied his inexperience, landed a succession of soft left-hand punches to the face. The Lynn boxer opened the second with a fierce assault of wild punching; Davidson survived well by keeping cool, and when his opponent tired, so punished him that the referee stopped the contest at the end of the round.

Edgar, upright and pugilistic, led narrowly at the end of a defensive opening, and though both threw an equal number of punches, increased his lead by landing more in the second.

In the third, Elroy (Lynn) caught him a few times on the chin, and Edgar, throwing the odd wild swing, just lost this round, but at the bell, with both very tired he had done enough to win.

Aspin and Quintin (Fitzroy) failed to land any punches until the end of the second, when Aspin opened his account with two right hand punches to the body. The third livened briefly and Aspin eventually beat a very slow opponent with a minimum of points.

In comparison the next fight was an all-action affair. In many wild clashes, Marsh, looking fit, strong and very evil, overcame his inexperience with some good in-fighting. Though there were few good punches, both boxers had the crowd on their feet, and were still fighting toe-to-toe at the final bell. The fact that they appeared from the wrong corners cannot have helped the judges with a difficult decision, which Marsh just won.

In the last bout, Hartley and Gregory (Fitzroy) both boxed well, with many punches being blocked by the gloves. Gregory, looking efficient, was unable to pierce Hartley's defence until, with half a minute of the second remaining, he caught him on the ropes, and landed an extremely good left to the side of the head which put Hartley down for the count, a little unluckily as he had been fighting so well until then.

J. SIEGLE

BOAT CLUB

The following account sums up the activities of the boat club during the winter term, with the exception of the 1st VIII, whose activities will be described by the club captain, Peter Burton.

Though the results of the term's efforts show less tangible returns than last term's, they are nonetheless useful and relevant.

The winter term is generally regarded as a season for training, ending with long gruelling races of up to four miles. These prepare the ground for next term's sprint regattas.

Despite the usual troubles with weather on the tideway and illness in the crews, rowing has proceeded steadily. It is satisfying to reflect that the 2nd and 3rd VIII's include twelve novices, but less satisfying that we have had a great lack of coaching, so that style has not kept pace with fitness. We hope to remedy this next term.

In the 2nd VIII both P. Hunt and P. Sharpe show considerable promise, whilst J. Rosenberg has done good work in the 3rd VIII. A. Taylor has not only stroked the 3rd VIII but has instilled considerable enthusiasm into the crew.

Wednesday, the 2nd of March, saw the day of our first race, the U.L. Head Race. Inexperience gave both crews an uncomfortable row in difficult water. The 2nd VIII maintained their finishing position at 18th, an improvement over last year when they finished 23rd, but the 3rd VIII did not fare so well. Starting last, they had no competition and rowed rather slowly finishing last.

At Bedford, on the following Saturday, both crews fared better, gaining more in racing experience. Being new entries we have no comparable result from previous years, but the two eights finished 33rd and 45th respectively out of an entry of forty-seven crews. The times, in sluggish water, were very fast, and the whole event was well organised on a beautiful day, so that an enjoyable time was had by all.

Only the 2nd VIII rowed at Reading on Saturday, 12th March. It was not possible, despite heroic effort, to obtain a boat for the 3rd VIII. However, the 2nd VIII showed considerable improvement, and rowed as never before. There was a danger of their "blowing-up", especially when nearing the end of the 3¼-mile course. There was considerable danger of catching a crab whilst overtaking other crews, but fortunately this did not happen. The finishing position was 130th instead of 142nd last year. This result is very significant since this is a very competitive race, including the Oxford Boat Race crew, and last year's result was also an improvement on the previous year.

The Tideway Head of the River Race is the culmination of the winter season, and this year well over 3,000 oarsmen took part. Guy's entered a record number of four crews. The 2nd VIII rowed with a substitute at 4, and thanks are due to K. Sommi who stepped into the gap at the last minute. The race was deliberately rowed at a low rating. Paddling at 28, the crew maintained its position until Hammersmith Bridge, despite a light crab at the Doves. The low rating began to pay off and several crews were overtaken near Harrod's. These crews acted as useful pace-makers as they raised their rating whilst trying to maintain their positions. Our final position was 233rd in a time of 21 mins. 13 secs. compared with last year's final position of 266th.

The 3rd VIII also had bad luck, in that the university boat booked for them was sold on the morning of the race, due to a mistake by the university organisation. They had to row for their first time ever in a shell eight, in an important race. However, they rowed superbly starting 316th and finishing 311th in a time of 23 mins. 13 secs.

Traditionally Guy's enter a gentlemen's crew for the Tideway Race. This year the 4th VIII astounded everyone by not finishing last, as they usually do. Not only did they overtake several crews, but they also moved up from 327th to 312th behind the 3rd VIII. Tony Pickering steered a magnificent course, despite its manifest illegality, and even a small collision. His steering must have been worth at least five lengths to the crew.

Crews:

2nd VIII:	**3rd VIII:**
Bow P. Sharpe	Bow J. Bates
2 P. Moulder	2 T. Haywood
3 J. Williams	3 M. Bishop
4 A. Bell	4 N. Longhurst
5 J. Pitt-Payne	5 J. Rosenberg
6 P. Hunt	6 Tudor-Williams
7 J. Swain	7 N. Daws (Capt.)
Stroke J. Skuse (Capt.)	Stroke A. Taylor
Cox J. P. Jago	Cox P. Trenchard

Gentlemen's VIII:	
Bow D. Kennedy	5 R. Morgan
2 R. Archer	6 P. Telling
3 P. Sharp	7 N. Watson
4 T. Peet	Stroke C. Soutar
	Cox A. Pickering

JONATHAN WILLIAMS

SQUASH CLUB

Results for the second half of the season:

Cumberland Cup: won 4, lost 1.

"Friendlies": won 5, lost 5.

Hospitals' Cup: lost to the London Hospital 1—3.

The second half of the season, like the first, has been very enjoyable and successful. There were, however, two unfortunate losses, which marred some good results in the "friendly" matches. The most disappointing was to lose to the London Hospital in the Hospitals' Cup competition. This was a contest between two evenly matched teams which resolved around two very close games. J. H. Newman gave us a good start by beating another ex-Cambridge blue 3—1; and the match was levelled by their winning at No. 2. Unfortunately both E. P. Davies and C. L. Newman lost after being ahead in their matches, and we were not able to give J. H. Topham the opportunity of playing the deciding game. Our 100 per cent record in the Cumberland Cup was destroyed when we lost to the West London Club who had gained considerable reinforcements since our victory over them before Christmas. This, however, was by the narrowest margin (2—3) and it cannot prevent our gaining promotion to the 3rd division for next year.

To balance against these losses we had a notable 5—0 win against Bart's; and a similar clean sweep against a weakened St. Thomas's team.

More interest than usual was centred around the internal individual competition which had twenty entries. This year there was a Cup at stake for the first time: for this we have to thank the generosity of our President and Vice-Presidents over the last few years, and also to a lesser extent, the Club Union fund. The Cup was won by J. H. Newman, who beat all-comers fairly comfortably.

To summarise the whole season, it is fair to say that this has been the most successful one for several years; we can look forward to next season, with the same team, hoping to consolidate our position in the Cumberland Cup, and perhaps even gain promotion again.

Teams:

Hospitals' Cup: J. H. Newman (Capt.), J. R. Webb, E. P. Davis, J. H. Topham, C. L. Newman

Cumberland Cup: J. H. Newman, J. R. Webb, E. P. Davis, M. Karmen (or N. M. White), J. H. Topham.

E. P. DAVIS

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Psychological Medicine,** from 1st June—30th September, 1966 in the first instance. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **20th April, 1966.**

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for a post of **Senior Lecturer or Lecturer in Histology/Cytology in the Anatomy Department,** the appointment to date from 1st October, 1966, or possibly earlier, by arrangement. Salary ranges: Senior Lecturer £2,520 to £3,255; or Lecturer £1,895 to £2,630, plus London Allowance, with superannuation; initial salary according to qualifications and experience. Applications should be made on a form obtainable from the Dean, Guy's Hospital Medical School, London Bridge, S.E.1.

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J. J. Halliday

GUY'S HOSPITAL, S.E.1.
SCHOOL OF NURSING

The following Nurses have passed the Final State Examination held in February, 1966:—

Anderson, S. J. M.
Austen, S. E.
Ayling, C. M.
Barnish, R.
Barnes, D. C.
Bayes, V. M. M.
Bellamy, E. A.
Blaikley, S. M.
Burrows, S.
Caldcleugh, H. E.
Carpenter, H. A.
Chapman, D. M. W.
Cleary, M. E.
De Mierre, C. J.
Dobson, A. D. S.
Domaingue, R. J. (née Webb)
Dow, E. A. E.
East, C.
Edwards, M.
Ellis, C. J.
Farmer, J. Y.
Fundell, M.
Gain, J. M.
Hanratty, C. A.
Hapgood, J. M.
Harding, C. A. C.
Hartwell, P.
Hindle, B. R.
House, S. E.
Jacob, L.
Jubb, E. M. H.
Kirkwood, V.
Lyth, E.
Methven, S. J.
Miller, E. A.
Milne, L. M.
Morgetroyd, J.
Morley, G. A.
Morris, J. A.
Musson, J. C.
Nancarrow, J. M.
Owen, A. J.
Pacey, V. E.
Palmer, B. E.
Phillips, C.
Phillips, R. M.
Ricketts, R. M.
Rowley, E.
Saunders, M. A.
Scarlett, C.
Sheppard, L. R.
Slade, B. D.
Stewart, A.
Stockdale, V. M.
Sutterby, S. E.
Sutton, R. M.
Talbot, E. M.
Taylor, C. E. M.
Tucker, S. R. H.
West, S. A.
Yorke, A. M.
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WATERS.—Dr. and Mrs. David B. Waters, to 3, Seifton Lane, Culmington, Nr. Ludlow, Salop. We apologise for the mistake made in this change of address in our issue of 19th March, 1966.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

BIRTHS

EVANS.—On March 22nd, at 16, Cope Edge Avenue, Epsom, to Anne (née Thomas) and Dr. Howard Evans, a daughter, Marian Lynne, sister for Susan.

STANFORD.—On March 13th, at Cherry Orchard, Otham, Kent, to Cynthia (née Chesson, S.R.N.) and Dr. John Stanford, a son, Richard Matthew, a brother for Anna, Mark and Jane.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT G. E. RATCLIFFE
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A New Physics of Matter and Energy

By
the late J. A. NASSIM
M.D., M.B., B.S., M.R.C.S., L.R.C.P.

Extracts from Preface. This book is aimed primarily at those who have yearned for a true understanding of the basic laws of nature, the physical laws. It is aimed at all theoretical and experimental physicists who may like to venture on a novel approach. Even more, it is aimed at those physicists who may find the attempt to depart from the abstract formulation of physics actually refreshing and a challenge which must sooner or later be taken up. Those who are interested or intrigued by the subject-matter, but find their mathematical equipment inadequate, should not be daunted from making their assault, for the mathematics invariably lead to simple concepts and conclusions which are easily comprehensible, yet make potentially exciting reading for all who have thought deeply about the subject.

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Chapter 4. New derivation of the fine structure formula in vibration-relativity theory.
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Chapter 6. A new unified theory. Magnetic phenomena in radiation field theory.
Chapter 7. Vibration-relativity and wave-mechanics. New interpretation of the wave function.
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References:
1. Meffert & Hoskins: J. Periodont, 35:232-35 (May-June) 1964. 2. Zelman & Hillyer: New York J. Dent 33:259-62 (Aug.-Sept.) 1963. 3. Skurnik: J. Periodont, 34:183-185 (March) 1963. 4. Cohen: Oral Surg., Oral Med., Oral Path. 14:1046-52 (Sept.) 1961. 5 Ross: J. Periodont. 32:49-53 (Jan.) 1961.

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Out of uniform

The Matrons of the London Teaching Hospitals have decided not to allow nurses to wear their uniforms while helping to raise money for charity. This has been the cause of much concern to the Mayor of Southwark's Boxing Committee, as Guy's nurses usually sell programmes in full uniform at their annual tournament. The Boxing Committee feel that people are more generous when they are approached by a nurse in uniform. The Matrons, however, have decided that it is time that nurses were recognized as specialized members of medical teams rather than pretty little things appealing for the extra few shillings for charity.

This is progress, but perhaps further consideration of the public's attitude to the nurses' uniform may be rewarding. The uniform is as unique as that of the Lifeguards and belongs to the same sort of pageantry. However, unlike the nurses, the Lifeguards have progressed since the Crimean war and wear suitable uniforms on the battlefield.

Nightingale herself might have accepted the present uniform years ago. Attitudes which necessitate the retention of this uniform are an anachronism in a modern profession. If the Matrons wish to bring the nurses' image up to date, then there will be a need for more radical thinking than that which resulted in their present ban on charities.

Guy's Student Education Committee

The elections for the Education Committee are being held on Monday, the 9th of May, the nominations for candidates closing on Thursday, the 5th. In this edition of the *Gazette* we print a brief account of the achievements and aims of this committee, written by Hugh Sturzaker.

Time alone will judge the ultimate value to Guy's in possessing a voice from those on the receiving end of the Medical curriculum. The individual student has a duty towards those who are affording his education to do what he can to help improve it, however modest this may be. That every student can now demonstrate this responsibility by judicious voting or by standing for election is a welcome new development.

M.B. or not M.B.

The present dichotomy in the London M.B., B.S. examination must eventually detract from its significance as a qualifying degree. There has been a trend for some years for hospitals to set their own internal examinations which are recognized by the Senate. These papers differ greatly in form and complexity. While the whole idea of examinations for medical degrees could be questioned, a candidate's chances of success should at least depend on his ability. The lack of uniformity in the present system involves factors which may favour some students and impede others.

The University defines the form of the course of each medical school, and evidence has to be submitted to the Senate that each student has completed the course before he is allowed to sit the examination. It is inconsistent that while it makes these demands, the University allows Medical schools to set their own internal examinations if they so desire. If London University wishes to grant an M.B., B.S. degree then it should take responsibility for standardizing the examination or it should cease to grant the degree, which would then become the qualification of each Medical school acting autonomously. The present system is falling somewhere between the two, and eventually, if the degree has any prestige value at all, this will deteriorate because of the inequalities in its examination system.

Whose Associations

On the 18th of April, the British Medical Students' Association completed its 25th Annual General Meeting. The week before it had held a highly successful National Clinical Conference on "Perspectives in Medicine". This year the Association was very fortunate in acquiring Sir Arthur Porritt as its Honorary President. At a dinner given at B.M.A. House for the various delegates from nearly all the Medical Schools in Britain and some from abroad, he delivered a fine speech of thanks. Also in it he expressed hope that it would soon be possible for doctors to go abroad for a few years after qualifying without being penalised as regards obtaining the better jobs on their return.

Both this meeting and the preceding Clinical Conference were organized by Robert Lane, of Guy's. They were of a high standard and were encouragingly well attended. However, the same could not be said of all the Association's activities. Like the more senior B.M.A., it enjoys very little enthusiasm at the grass roots level. Yet both these organizations achieve quite a considerable amount for the common good, despite the fact that their work is undertaken by a comparative few. The inadequacies and in the case of the B.M.A. constitutional injustices, that do exist are in reality

the group responsibility of the profession. But it seems that the highly commendable reluctance of Medicine to have anything to do with party politics has become extended to all forms of organization. And that so many doctors are unprepared to devote even as little as half an hour a year to supporting or assisting in the affairs of the profession is nothing that we can be proud of. Yet criticisms and grumbles are all too frequent from medical men who have been too ready to leave the management of their public business to an overworked few, without so much as the offer of accurate information or minimal help. Surely, with lessons learnt from the crisis that has arisen in manpower, equipment and basic contentment, we can approach the tasks of co-operation and planning with more effectiveness. And rather than allay our consciences in futile grumbles we must resolve to change from within that which we find unacceptable in our Associations.

One of the social highlights of the hospital year, the Residents' Ball, is getting nearer. We are informed that there are still many tickets available. They can be obtained at the Appointments Bureau or from Murray Roberts at the East Wing.

Dr. J. Hellewell has been appointed consultant anaesthetist as from June the 1st, 1966.

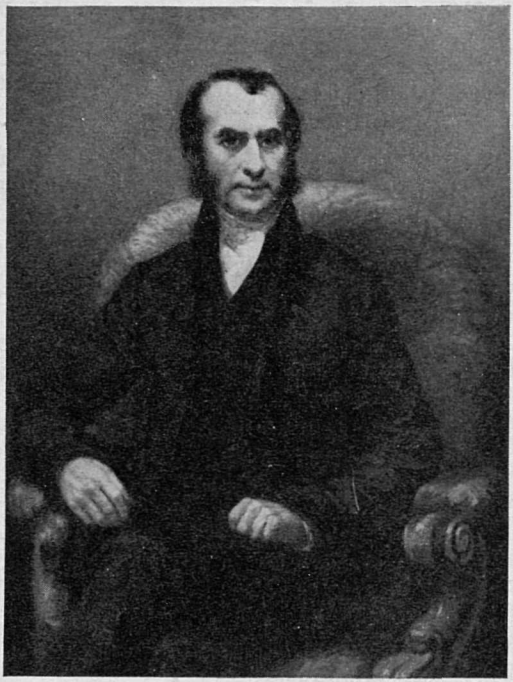
GUY'S DIARY

MAY

2nd	M.	1.00	Dr. FLEMINGER. "Psychiatric Aspects of Sleep".
3rd	T.	1.00	Dr. BLACKBURN.
5th	Th.	1.00	Dr. DOW.
		5.00	Psychological Society. "Schizophrenia", by Dr. BANNISTER.
6th	F.	1.00	Professor TROUNCE. "Anti-Inflammatory Agents".
10th	T.	1.00	Mr. KILPATRICK. "Kidney Tumours".
12th	Th.	1.00	Mr. LAWRIE.
13th	F.	1.00	Dr. KAUNTZE. "Carcinoma Bronchi".

THOMAS HODGKIN AND GUY'S

by Dr. C. Hardwick



"Whilst I am fully sensible of the honour which has been done me by placing me in the position which I now hold before you, I must tell you that I feel myself taken by surprise having neither expected nor desired it. I regret that another individual had not been selected in my stead, not from the want of respect to you or of attachment

to the Society in whose prosperity I feel a lively interest, but because I think that the interest of the Society might have been more promoted by the selection of a more able and distinguished individual, whilst those exertions which it is a pleasure for me to make in the service of the Society are better suited to a less prominent position in it.

"I have very recently been greatly annoyed by the singularly uncourteous and unhandsome conduct of the managers of the medical school at St. Thomas's, which, during the last year, have absorbed a large portion of my time, attention and labour. Miserable intrigues, of which I regret to say that some members of our profession were at the bottom, have been carried on so as to erase my name from the list of lecturers without consulting me on the subject, or assigning a reason.

"Thou knowest that the people of Guy's used me very ill, but those of St. Thomas's have been still more regardless of even the form of courtesy."

These words are, of course, those of Thomas Hodgkin, but I have chosen them because they describe very eloquently two features of our commemorative exercises. The first is my own inadequacy at being asked to write about Hodgkin and Guy's. This inadequacy would have been total, were it not for the wise and encyclopaedic advice that I have received from Mr. Hill, the Wills Librarian, to whom I am most grateful. It will be apparent that I have drawn freely from Wilks and Bettany's "History of Guy's Hospital" and from Hector Cameron's "Mr. Guy's Hospital". The second of my two quotations is from a letter written by Hodgkin to an old friend, which is in the possession of the Royal College of Physicians, which helps to explain the inevitable air of "amende honorable" which must colour much of our discussions about Hodgkin.

Hodgkin came to Guy's as a student and graduated at Edinburgh in 1823. In 1925 he was invited to return to Guy's by Sir Astley Cooper and was made Demonstrator of Morbid Anatomy and Curator of the Museum by the Treasurer of the Hospital, Benjamin Harrison, the Junior. It is of interest that a few months later, in February 1926, Joseph Towne, the modeller, was given a post in the Museum, also at the prompting of Astley Cooper.

The year 1825 was an important one for Guy's. Earlier that year the partnership between the Hospital and St. Thomas's on the other side of St. Thomas's Street, which had provided the United Anatomical and Surgical School of the Boro' Hospitals, came to an end amid considerable acrimony. It was decided that Guy's should start a School of Anatomy and Surgery itself, in addition to the teaching of medicine and midwifery which was already given. Accordingly, in April 1825, the Court of Committees resolved:—

"That an Anatomical Theatre, Museum, Dissecting Room and other requisite offices be built on the vacant freehold in Maze Pond. . . ."

It seems incredible that the idea was conceived, the plans laid, the buildings built, the staff engaged and the new School opened, all in the space of six months!

It was to this new Department and to the Museum that had been built, roughly where Nuffield House now stands, that Thomas Hodgkin came. It had been anticipated that the nucleus of the museum would have been formed by Astley Cooper's own collection of specimens, but this was retained by St. Thomas's, although the £1,000 which they paid for it was put to the building fund.

Hodgkin threw himself enthusiastically into his new duties and he ended his first lecture to the students with these words:—

> "I shall conclude by assuring you that it will be my constant aim—whether I may be fortunate enough to reach the mark or not—to co-operate with those who are strenuously endeavouring to render the School of Guy's Hospital the first medical school in the Kingdom."

Soon after his arrival at Guy's, Hodgkin was called upon to play a prominent part in the battles which at that time were being fought between the Hospital and Wakley, the Editor and founder of "The Lancet". The latter, in his campaign against what he considered to be nepotism in the large London Hospitals, had succeeded in getting an accomplice into the theatre at Guy's to watch Bransby Cooper, nephew of the great Astley Cooper, cut for the stone. The operation proved difficult and the patient died. This unfortunate outcome was attributed by "The Lancet" to the shortcomings of Bransby. It was Hodgkin's duty to perform the post mortem examination and the story is told that during the autopsy Hodgkin was called from the room, whereat the informant, who was again present, attempted to demonstrate to the audience that a hole had been made between the bladder and the rectum.

> "Sir," said Hodgkin, on his return, "thou hast made that opening thyself."

Perhaps it was this experience, and that in the witness box at Bransby's successful action for libel, that made Hodgkin advocate that space in the curriculum be found for Legal Medicine and for what he called the principles of medical police.

This latter suggestion, covering what now we should term the sphere of Public Health, must have seemed a very advanced one in 1828. It was indeed an idea of a twentieth century physician and, as we shall see, this is only one of many fields in which Thomas Hodgkin was a man before his time.

It is not proposed to deal with his outstanding contribution to Morbid Anatomy—of his full account of acute appendicitis and its complications, of his description of aortic regurgitation, or "retroversion of the valves of the aorta" as he called it, five years before Corrigan; and above all, his description of lymphadenomatosis, to which Sir Samuel Wilks gave the name of Hodgkin's disease in 1865. Mention must be made of his remarkable catalogue of the Museum. Produced only four years after its inception, nevertheless it was able to list no less than 1677 different specimens.

There are, however, many other activities of this remarkable man which do require attention and all of them have a very modern ring. For instance, medical education, especially his labour for London University as a member of the Senate from the time of its inauguration until his death; his work in the field of the medical assessment of life assurance, first as medical officer and then as a director of the National Provident Institution; his philanthropy and his interest in the coloured races and the abolition of slavery. Later in his life there were his travels, which produced papers such as: "On some superficial Geological Appearances in North-Western Morocco", or "On the state of the Guanches, the extinct inhabitants of the Canary Islands". Elsewhere amongst his writings we find topics touched upon include "The Dog as the Companion of Man", "Trades Unions", and "The Merits of the Decimal System".

Medical Education was the topic of his Presidential address to the Physical Society, at the opening of the new session in 1827. This paper is another of the twentieth, rather than the nineteenth, century and those who are concerned with the same subject to-day and who are anxious to impress the Royal Commission with their modern ideas, would do well to read what Hodgkin said so long ago. Amongst other topics, he discussed pre-medical requirements, the dangers of excessive detail in the pre-clinical subjects, the need for the emphasis in the clinical period to be on basic principles, and the dangers of allowing the newly-qualified student to go into practice too soon. This, he said:—

> "is extremely liable to induce a superficial manner of viewing disease."

He even advocated that those students who intended to go into practice should have their clinical experience, not in hospitals but in dispensaries.

But perhaps the most interesting idea in this important paper is Hodgkin's advocacy of the need to have ward clerks in the medical wards, comparable to the dressers who for so long had worked in the surgical wards. He described the idea thus:—

> "The Plan which I would recommend would be for the students on entering to the practice of medicine, whilst they would be at liberty to see all the medical patients, to attach themselves more especially to some one of the Physicians, precisely as the Dressers are accustomed to do with respect to the Surgeons, with this only difference that the number attached to each needs to be limited. . . ."
>
> ". . . The histories taken by the Pupils, would not merely assist them in making valuable remarks on the progress of the disease, but would be highly beneficial to the students themselves, by sharpening their powers of observation, and in inducing a facility and an address on medical subjects."

This subject was one which continued to interest him but there was opposition to what must have seemed to be very advanced views. However, Hodgkin was no iconoclast and in 1843 we find him writing to an old friend as follows:—

> ". . . The other subject is that of Medical Reform to which I have paid considerable attention, which I think might be effected to general advantage and satisfaction whilst yet retaining so much of the present forms as to avoid shocking those who would be alarmed at seeing a total overthrow of that which time may seem to them to have consecrated."

Hodgkin had earlier travelled much on the continent and as a result of his visit to Laennec he had brought back the stethoscope and was probably the first to use such an instrument at Guy's. He came to be regarded as the foremost morbid anatomist of his day but he was also occupied in seeing patients, though his house in Bedford Square was more often full of philanthropists and ethnologists.

Speculation as to why someone fails to get elected to the staff of a hospital is never a very rewarding or edifying exercise. It is easy at this distance to say how wrong Harrison was in choosing Benjamin Guy Babington, the brilliant son of a distinguished father, to be Assistant Physician to the Hospital rather than Hodgkin. But was this choice wrong?

This was a position with care of patients and Hodgkin's prowess was known to be particularly as a morbid anatomist. Consulting work does not seem to have been his métier. Perhaps there were too many ideas fermenting in his capacious brain, so much to be done to improve the lot of his fellow-men around him and so little time in which to do it. Worldly goods did not attract him; marriage—to a widow—came late in life and he did not have the stimulus of a large and growing family to send him into the market places of medicine. (Among his patients, however, was a youth called Lister, who had suffered a breakdown, in health and spirits, at the commencement of his medical career. Perhaps in restoring this young man to health Hodgkin made his greatest contribution to British Surgery.) In most characteristic vein is the story of how he sat all night at the bedside of a patient who had a very large fortune; for his pains he was given a blank cheque, which he filled in for the sum of only ten pounds. To add insult to injury he explained his action to the patient by saying he did not look as though he could afford more! This habit of undercharging his patients came in for considerable criticism from his colleagues.

On the other hand, Babington had served in India, was particularly familiar with cholera and was an expert on the various fevers which formed such a large part of the admissions to hospital in those days. He later became the first president of the Epidemiological Society and amongst his other accomplishments was his invention of the laryngoscope. He had been elected a Fellow of the Royal College

of Physicians in 1831. Hodgkin himself was invited to become a Fellow in 1836, which must have been a signal honour, as only in the previous year had the College rule that all Fellows must be graduates of Oxford or Cambridge been abandoned. However, Hodgkin refused this honour.

Hodgkin was extremely popular with the students. Coming to Guy's in 1825 we find him giving the inaugural address to the Physical Society, as one of its Presidents, in both 1827 and 1834. When he failed to get the nomination to the post of Assistant Physician in 1837 the students presented a memorandum to the Treasurer, expressing their dissatisfaction. But although he was popular with the students it must be confessed that there were features in his character which would not have been endearing to his colleagues, though he was on the best of terms with Babington, who gained the appointment to the staff.

In keeping with his Quaker faith he was at times outspoken in his criticisms of his colleagues. Thus, for instance, in his address to the Physical Society in 1834, he referred to the absence from the meeting of those members of the staff:—

> "who may not be more remotely placed than Bishopsgate Street, or Bond Street, Spring Gardens, or some of the meanest villages to which London practitioners have followed their patients."

This is evidently a reference, amongst others, to Addison and Bransby Cooper.

Another reason for his unpopularity may have been his interest in coloured people and his efforts to improve their lot and to abolish slavery. He was one of the founders of the Aborigines Protection Society and one of his habits, to which Benjamin Harrison took great exception, was that of driving through London with a coloured person sitting next to him.

Finally, there was his connection with London University, where he was a member of the Senate from its inception until his death. He was zealous in carrying out his duties and there is in existence a letter which he wrote to regret his inability to attend the meeting to set the questions for the Matriculation examination because of his absence abroad.

It is difficult at this distance to appreciate the opposition which the new University met. When it proposed to grant medical degrees, Guy's was very disturbed and the Court, at the prompting of Treasurer Harrison in 1833, passed the following resolution:—

> "That notice having been given of an application to Parliament to petition that a Charter may be granted to the London University to enable them to grant Degrees in Medicine. It is considered that such a privilege would be of great injury to the Medical School of this institution.

> " 'ORDERED: that the Treasurer be authorised to prepare a petition and that the Hospital Seal should be affixed thereto and to have the same presented to the House of Commons if it should be desirable so to do'."

This resolution was passed some four years before the vacancy on the staff occurred and Hodgkin's work for the new University had not gone unnoticed by the Treasurer. And so, for a variety of reasons, the choice fell upon Babington and Hodgkin left Guy's. After a short stay at St. Thomas's, where they were:—

> "still more regardless of even the form of courtesy",

he ceased, in 1843, to have any connection with any hospital, although he continued to practise medicine and was President of the Harvean Society in 1847. His writings included papers on medical subjects but there are increasing numbers on other topics.

In 1866 he set out for the Holy Land with his old friend Sir Moses Montefiori, who tells us that for some time Hodgkin had been in poor health,

> "and, indeed, he left home to accompany me on my journey, in the hope and belief that the voyage and change of air would prove beneficial to him."

When they reached Jaffa, Hodgkin became worse and further travel became impossible. Sir Moses arranged for him to stay with the British Consul and secured the professional services of Dr. Sozzi, the physician of the Lazaretto, leaving his own personal servant to be in constant attendance on his esteemed friend whilst he himself went on to Jerusalem.

On April 6th, Hodgkin died and, as Sir Moses wrote:—

> "It has pleased the Almighty to take him from us, and that he should not again behold his loving consort and beloved relatives; he breathed his last in a land endeared to him by hallowed reminiscences. To one so guileless, so pious, so amiable in private life, so respected in his public career, and so desirous to assist with all his heart in the amelioration of the condition of the human race, death could not have had any terror; his soul has ascended to appear before the Throne of Glory, there to receive that heavenly recompense which is accorded to the good and righteous of all nations."

SMOKING

by

Dr. Michael Bott

The sight of someone smoking a cigarette is so commonplace in our society that it is unlikely to evoke comment or thought. However, the publication of work on the relationship between cigarette smoking and lung cancer was responsible for a great deal of research into the reasons why people smoke and the various ways in which smokers and non-smokers differ from each other and finally the reasons why people give up smoking or persist with the habit even in the presence of disease. The validity of the relationship between cigarette smoking and lung cancer is outside the scope of this article since here we are principally concerned with psychological aspects of smoking.

Most workers think that there are differing reasons why people begin and why they continue to smoke. The example of smoking adults and older teenagers, are probably the most important factor in the initial attempts at smoking. Phanishayi's work on 48 male college graduate and post-graduate students, in which he used a questionnaire designed to establish the reasons why his subjects began to smoke and also why they continued to do so showed that 75 per cent tried their first cigarette to "see what sort of pleasure I would get out of it". Other reasons given were: "I thought that there was nothing wrong in doing so" (52 per cent); "I thought it would help me sit up during nights for study" (50 per cent); "I thought there must be something attractive about it because so many people do so" (48 per cent); and finally, "I thought a trial would cost me nothing" (48 per cent). Rather surprisingly, the reasons with the lowest frequency were: "I was tempted by the advertisements" (4 per cent); "I wanted to rebel against the authority of my parents and smoking is one way of doing so" (4 per cent).

In 1959, Horne and his co-workers studied 22,000 high school students in the Portland, Oregon, area to establish their smoking behaviour and attitudes. They found that the percentage of smokers was greatest in those families in which both parents smoked and least in the families where neither parent smoked, second that the percentage of smokers is higher in the group of students who do not

participate in any school activities, third that the percentage of smokers is inversely proportional to the educational level of the parents, and finally that the percentage of smokers is higher in those children who are behind their age-equals academically.

At the age of ten years about 10-15 per cent of boys smoke small numbers of cigarettes, often with parental consent. During the years 10 to 15 there is a steady rise, with an abrupt increase between 15 and 16 associated with school leaving. About 30 per cent of 15 year-old boys smoke, at 16 over 50 per cent and this figure rises to 60 per cent at 18 and the adult figure of 70 per cent by the age of 19. At the age of 15 only about a sixth of the 30 per cent who smoke are smoking more than 5 cigarettes a day, by the age of 19 well over half the smokers are smoking more than 6 cigarettes daily.

School girls smoke less often than boys: about 15 per cent at age 15 and 40 per cent by age 20.

The factors which are responsible for the continuation of the habit of cigarette smoking after the first trials on the basis of adolescent curiosity and striving for adult status have been the subject of a great deal of research. Some authors stress the pharmacological aspects, others personality and related genetic factors and finally others the habituation which takes place and the many psychosocial associations which surround the smoking habit.

During adult life over 70 per cent of adult men and 50 per cent of adult women are regular cigarette smokers. The average consumption of men is 19 cigarettes daily, while women average 11 cigarettes a day. These figures may be broken down further as follows:—

	Men	Women
1–5 cigarettes daily ...	18%	36%
6–10 „ „ ...	21%	33%
11–20 „ „ ...	42%	26%
20+ „ „ ...	19%	5%

The precise pharmacological effects of nicotine on the human subject are variable and unpredictable at different times even in the same individual with the same dose of drug. Moderate doses of nicotine elicit marked increases in respiratory, vasomotor and emetic activity, and still larger doses lead to tremors and convulsions. The emetic properties are more marked in the novice smoker but may occur in heavy smokers with excessive use of tobacco. Nicotine produces a depression of the voltage of alpha activity together with an increase in frequency in the E.E.G.; this is equated with arousal. However, the same changes in the E.E.G. can be produced when the subjects "smoke" a glass cigarette stuffed with cotton wool or a cigarette made with nicotine-free tobacco. Hauser et al, who made these observations, concluded that the changes represented a psychophysiologic response to the act of smoking. The action of nicotine on the gastro-intestinal tract is to reduce gastric motility, particularly hunger contractions. Nicotine also stimulates peristalsis but there is great individual variation. Excessive smoking may be associated with constipation or diarrhoea. Peripheral vasoconstriction and a rise of systolic blood pressure occur with a dose of nicotine comparable with that absorbed when a cigarette is smoked, e.g., 1-2 mg.

The measured effects of cigarette smoking and the effects which smokers claim to occur are worth looking at more closely.

Some smokers claim that cigarettes help them to relax, to concentrate, to sleep, to stay awake, to get over difficult situations and to feel self-assured. It would appear that we are dealing with a plastic agent, a sort of universal panacea. Into this aspect of smoking one must next introduce the concept of association. A man who smokes 20 cigarettes a day goes through the motion of lighting and smoking a cigarette 7,000 times a year and he does this in a pattern so that, for example, when he sits down to relax, or when he is about to start a difficult task, he lights a cigarette, and in this way the need for relaxation and the smoking of a cigarette become inextricably associated. Once a smoker has reached this stage he may be regarded as an habitual smoker. However, deprivation of cigarettes will produce tension and irritability because the pattern of behaviour will be incomplete and the individual's method of dealing with anxiety-provoking situations has been disturbed.

Smokers differ in the reasons why they smoke as evidenced by the effects they consider cigarettes produce, for some the social aspect is important, in others the relief of tension is more important.

In general, unlike the other social habits of coffee, tea and alcohol drinking, most smokers tend to smoke regularly although some smokers do manage to limit their intake, the more usual pattern is of gradually increasing consumption.

Eysenck, in his investigation of the relation between smoking and personality, found that smokers were more extraverted than non-smokers and that heavy smokers were the most extraverted of all. Eysenck describes the typical extravert as "sociable, likes parties, has many friends, needs to have people to talk to, dislikes reading or studying by himself, craves excitement, takes chances, acts impulsively, is carefree, easy going, optimistic and likes to laugh and be merry. By comparison, the typical intravert is "quiet and retiring, introspective, preferring books to people, is reticent except with intimate friends, he plans ahead, dislikes excitement, keeps his feelings under control. He is reliable, somewhat pessimistic and sets great value by ethical standards".

Eysenck considers that these extremes of personality are distinguished by their reaction to stimulation and the amount of cerebral inhibition which is normally present. Extraverts are characterised by a high level of cortical inhibition and therefore they are found to derive greater pleasure from higher levels of stimulation. In Eysenck's view, this is why they seek nicotine, which he considers to be a stimulant drug. This latter view is somewhat at variance with observed data, for many cigarette smokers are also found to be heavy coffee drinkers (stimulant) but also fond of alcohol, which is a sedative. And, indeed, in view of the effect on E.E.G. of dummy cigarettes, it may be social stimulation which the extravert craves. Eysenck also investigated his subjects to see if he could demonstrate any relationship between neurotic characteristics and cigarette consumption. He was unable to do so, but thought that inhaling may be more prevalent among the emotionally disturbed.

However, Matarazzo and also Lawton and Phillips, both in America, found evidence of greater anxiety among heavy cigarette smokers.

The earlier results in children showing that cigarette smoking tended to be associated with under-achievement, prompts us to measure the I.Q. of smokers. Matarazzo and Saslow found no correlation between I.Q. and smoking habits, so one postulates that the under achievement is related more to the extravert personality than to compensatory cigarette addiction, which has been suggested as a reason by some authors.

The second part of Phanishayi's work on Indian college students was concerned with the reasons they gave for continuing to smoke. He found that the commonest reason was:—

It serves as a companion when I am alone (75%), followed by It warms me up when I am cold (71%), It helps me forget my worries and anxieties (60%), It facilitates thinking and gives inspiration (52%), It enables me to acquire new friends easily (44%).

In Great Britain there are about 21,000,000 smokers, who consume 125,000,000 cigarettes annually at a cost of £1,344 million. The tobacco industry spends about £16,000,000 annually on advertising its products. The suggestion that smoking and lung cancer were associated caused some hard thinking in American advertising agencies in the early 1950's. Most of the agencies provided and put out copy which claimed that so-and-so's cigarettes wouldn't kill you. The resulting fall in sales when people realised that there must be some association or why did the advertisers keep on mentioning it, prompted a study of smoking habits of a group of 350 smokers by Social Research Inc. They found that people smoke to relieve tension, to express sociability, as a reward for effort, as an aid to poise, as an aid in anticipating stress, as proof of daring, as proof of conformity and because it is an accustomed ritual. However, the major surprise was that Americans smoke to prove they are virile, vigorous and mature. "This is a psychological satisfaction sufficient to overcome health fears, to withstand moral censure and ridicule." The result of this survey was a rush of advertisements showing virile, mature men engaged in tough jobs. The importance of oral-gratification which the report also showed was emphasised in the advertisements—a trend which is still frequently seen in cigarette advertisements in this country. How powerful is this urge to continue smoking, and what do smokers think about the risk to their health?

In 1958 Cartwright, Martin and Thomson studied the effect of concentrated propaganda on the smoking habits of the residents of Edinburgh. The programme, which cost £4,350, consisted of advertising in the local newspapers stressing the risks of smoking, large posters on hoardings and smaller ones in factories, offices, clubs and so on, 30,000 copies of the B.M.A. leaflet "Smoking—the facts", a special leaflet for the campaign of which 150,000 were printed, a clear forceful letter from the M.O.H. of Edinburgh was sent to every household, 24 meetings were held, attended by 2,600 teachers, and every class of secondary school children was visited by a member of the health Department!

Two representative samples were drawn from the population, one was interviewed in November before the start of the campaign and the other six months later.

There was no indication that the campaign persuaded people to give up smoking. Some said they had reduced their consumption but this was not confirmed by the actual figures before and after the campaign.

The first survey revealed that 98 per cent of the sample had already heard of the association between smoking and lung cancer. After the campaign the number of people who accepted the hypothesis that smoking and lung cancer are associated was unchanged, but there was a rise in the number of subjects who thought that smoking was associated with cough, breathlessness and bronchitis and also an increase in the number of smokers—from 1 in 5 to 1 in 3, who thought that their health might suffer, but they didn't mention cancer in this. Cartwright et al considered that there are two main processes at work. Firstly, a form of emotional blockade, associated with the widespread fear of cancer. Second, a deflection and dilution of the hazard to present it in more familiar terms. Before the campaign 40 per cent said they would like to give up smoking, *the number was unchanged after the campaign.*

Some smokers do stop smoking. What distinguishes them from the remainder? Eysenck showed that ex-smokers had an extraversion score mid-way between light and moderate smokers. Hammond and Percy published a study of 333 ex-smokers. They found that 63 per cent gave up because of some condition made worse by smoking, cough and shortness of breath were the most common examples. Only 6.3 per cent stopped smoking because of reports linking smoking and lung cancer, a further 2.4 per cent gave up because of reports that smoking had a bad effect on health in general.

The other group whose smoking habits have been studied are a group of British doctors. When first studied in 1951 doctors in the sample showed fewer cigarette smokers and more non-smokers than among doctors as a whole. There were 40 per cent non-smokers and 38 per cent cigarette smokers. Ten years later the figures were 58 per cent non-smokers and 24 per cent cigarette smokers. During this same period the smoking habits of the population as a whole had not changed.

What methods are available to help people give up smoking? In spite of their pharmacological similarity compounds containing Lobeline are useless. Group therapy has its advocates, and treatment along similar lines to A.A. has proved helpful. Most of the smoking clinics which were started, seem to fade out after the initial surge of enthusiasm. Nearly all the studies published emphasise the importance of the patients motivation.

Deconditioning using hot cigarette smoke blown into the subject's face from a fan heater until he says, "I want to give up smoking", when it is replaced by menthol vapour is the method employed by Wilde. Vallance et al report one case treated by aversive conditioning using an electric shock as the stimulus.

In general, methods which provide alternative oral stimulation, reduce anxiety and destroy the multiple associations built up between smoking and other activities, will help the person attempting to give up smoking. Two factors, at least, militate against attempts to stop. First is the law of temporal succession which states that if an act has two consequences, one rewarding, the other punishing, which would be equal if simultaneous, then the effect on future performances of the act will depend on the order in which they occur. Thus, in smoking, the reward is immediate, the punishment distant. Secondly, if the subject sees cigarettes as relaxing and tension relieving, the temptation to have just one cigarette may prove overwhelming.

The present ban on television advertising of tobacco products is undoubtedly a step in the right direction, but the recent collection of posters depicting a pound note in flames seemed rather ineffectual beside the tobacco companies' multi-million-pound programme of persuasion.

What is required from a psychological point of view is to replace tobacco by some portable, non-toxic, anxiety relieving, masculinity and virility symbolising substance which the government can tax, and then we could get down to the business of eliminating tobacco smoking with all its attendant danger, to say nothing of an annual fire bill of some £10 million.

NOTICES

Memorial Service

There will be a Memorial Service for Mr. W. D. Doherty on Monday, May 2nd, 1966, at 12.30 p.m. in Guy's Hospital Chapel.

R. J. CANN,
Acting Superintendent.

Residents' Ball

The Residents' Ball is one of the annual social highlights of the Hospital. This year's Ball, which will be held on May 13th at Grosvenor House, Park Lane, will be particularly entertaining. There will be dancing to Bill Saville and his band, and a cabaret by the Footlights of Cambridge University. Students and nurses will be especially welcome. Tickets are still available from Mr. Goodliffe at the Appointments Bureau or from A. M. Roberts at the East Wing.

P. D. DAVIES,
Sec., Ball Committee.

Guy's Sixty-Six Club

Medical students qualifying this year are invited to join Guy's Sixty-Six Club. All people interested are asked to contact myself or P. Underwood at the East Wing.

BRIAN VALLENTINE,
Acting Secretary.

B.M.S.A. Hop

The B.M.S.A. is holding its annual " all night jazz hop " in the Chislehurst Caves this year on 20th May. Dancing to a dozen bands from 10 p.m. to 6 a.m. Food and drink will be available in the Caves. For tickets please contact R. Leete, M. Simpson or Miss A. Hill. All are welcome.

WILLIAM DAVID DOHERTY

The unexpected death on March 31st of Mr. W. D. Doherty came as a great shock to all, including his many friends in South Africa. He was making good progress from a hip operation, when he died suddenly from an unrelated cause. William David Doherty was born on July 17th, 1893. He was educated at Dulwich College, then at King's College, Cambridge and entered Guy's Hospital Medical School in December, 1917.

At Guy's he was always known as "George"; to his family he was known as "Willy"; and to his friends at Dulwich and Cambridge as " Doggie."

He played rugger for Dulwich, and for three years he represented his school at the Public Schools' Boxing Championships held at Aldershot. In 1913, Doherty was a Cambridge Blue in a team which included two of his Dulwich friends, C. N. Lowe and J. E. Greenwood, whilst Eric Shand, another Old Alleynian, captained Oxford. After the war three of the above players were international captains: Greenwood leading England; Shand, Scotland; and Doherty, Ireland. Additionally, he was awarded a half-blue for water polo. At rugger, George captained Guy's for three years, and during this period he was capped seven times for Ireland, which he captained in 1921. The Guy's team in the post-war years was the finest club side in the country and included many famous players from South Africa and Wales. The outstanding success of the Guy's side was largely due to the leadership and personality of the captain. Eric Shand says George was the lightest and toughest forward, a player who was always on the ball, and a magnificent leader.

In 1914 he interrupted his career at Cambridge to volunteer for active service. He went to France with the R.A.S.C., and became a Captain. Then, owing to the shortage of doctors, he was brought back to resume his medical studies.

It would appear that George's athletic prowess endowed him with the tremendous mental stamina and balanced judgment which stand out in his clinical and subsequent administrative work. In 1920 he qualified, in 1923 he took the final F.R.C.S., and in 1925 the Cambridge M.Ch. In the face of severe competition of the post-war years, he became Assistant House Surgeon to "Joey" Hughes, and House Surgeon to Sir Alfred Fripp. Afterwards he was Anatomy

Demonstrator before becoming Surgical Registrar in 1923. These many years as Registrar were very formative in evolving "The George" as we knew him. He developed into a fine clinical teacher, stressing essential points in the patient's story and physical signs. His friendliness endeared him to all, students, nursing staff and patients. As a result, his advice on matters, both medical and non-medical, was often sought.

In 1931, George became Assistant Surgeon, but he was soon to abandon general surgery. In 1916 the Governors, with tremendous foresight, had established a Genito-Urinary Department at Guy's, with Mr. A. R. Thompson in charge. In 1936, on Mr. Thompson's retirement, the Governors happily invited George to take over. Soon, with the co-operation of his colleagues, he established a flourishing Urology Department, which continued until World War II, when all in-patient work was transferred to Orpington Hospital. Here he operated on two days a week, and on Friday nights he slept at Guy's and took his share of the surgical emergencies.

When George became Superintendent, he restricted his clinical work to the precincts of Guy's. In spite of the many demands on his time, he remained meticulous in his care of patients, and set a high standard for his juniors. His rounds, not necessarily confined to urology, covered many aspects of general surgery, to the surprise of many of his dressers. His teaching was reminiscent of Joey Hughes. George's many Registrars were always grateful for the operative surgery he taught them. It was his custom to be the first assistant, guiding the trainee through the steps of the operation. In his operating theatre he always managed to have a pleasant and peaceful atmosphere. As he became more senior he kept himself up-to-date—for example, he took up retropubic prostatectomy soon after Millin introduced the operation. Every nurse who has held a position of responsibility here at Guy's must, at some time, have felt the benefit of George's influence. Everyone knew that here was a sympathetic friend who could appreciate their problems and put them in the right perspective. He always seemed to have time to listen to one's problems and, as often as not, had a ready solution.

From early on his judgment, balance and shrewdness were outstanding. When necessary he could be firm, but always controlled his feelings. He had been Secretary to the Medical Committee and Sub-Dean during the difficult war years, so that in 1948 he was the obvious successor to Professor T. B. Johnston. Mr. Doherty, the Superintendent, was immediately deeply involved in the repair of the badly damaged hospital—some of the bombed wards in Guy's House had to be salvaged, and Departments such as Radiotherapy and Radiology required expansion and re-equipment. In addition, the future of the post-war hospital had to be planned.

Sir John Conybeare knew George very well indeed and on George's retirement in 1958, wrote:

"During his tenure of office as Superintendent, the building of New Guy's House has been a difficult and thorny problem, which has thrown an enormous amount of work both on the Governors and staff, and particularly on the Clerk to the Governors and the Superintendent. It is certainly gratifying for George on his retirement to see the long awaited new building rise above ground level.

Few will ever know how great a debt Guy's owes to George Doherty for the skill with which he guided the Hospital through the formative years of the National Health Service. How often have many of us gone to him with bitterness in our hearts at some new regulation, perhaps imposed from above. After a talk with George, we have left his office relatively pacified and perhaps better able to see more than one point of view.

Throughout his career at Guy's, and particularly during the last ten years, one of the most striking features about George Doherty has been his close and friendly relations, not only with the Governors and staff, but with junior staff, house officers and students. The number of Registrars, House Officers and Sisters who have enjoyed the Christmas parties given by George and Margaret in the Superintendent's house must run into thousands rather than hundreds, and their hospitality to his colleagues and to the Governors and, indeed, all those connected with Guy's, will be among our most pleasant memories of our hospital life."

Mr. Doherty's final appointment at Guy's was that of a Governor, in 1961. In this capacity he served on many sub-committees and was Chairman of the Nursing and Nurses' Education Committee, where his wise counsel was invaluable. He was also a Governor of Guy's Hospital Medical School, and of Alleyn's College of God's Gift.

George was always a very sociable person, and when he retired he now had time to enjoy meetings of "The Thirty Club", "Our Club", of which he was elected Chairman in 1965, and "The United or Boro' Hospitals' Club." He also devoted more time to Masonic activities.

George has been actively associated with Guy's for 49 years. His genial personality and friendliness will be sadly missed. To Margaret and her children we extend our deepest sympathy.

F.R.K.

DR. S. E. F. GOODING

Members of Guy's will be sorry to learn that Dr. Stanley Gooding, honorary lecturer in Pharmacology, collapsed and died while attending a service in Westminster Abbey on the 26th March, 1966.

Dr. Gooding, who studied at Cambridge and the London Hospital, started his happy relationship with Guy's in 1948 when he was appointed as full-time lecturer in pharmacology, and for the past 15 years has served as part-time honorary lecturer in the same department. During this time he regularly attended the Medical School to help in the running of the pharmacology practical classes. He was always a very popular teacher with the students, particularly because of the breadth of his experience, but also because of his very friendly nature which made him so approachable.

Because of his retiring nature, the students may not have realised the extent of his public life. After acting as a police surgeon for some years, he was appointed to the Bench in 1951, and since 1965 has been Chairman of the Malden and Surbiton Magistrates' Court. He was elected to the Surbiton Council in 1946 and was Mayor of Surbiton in 1950 and 1954. He was one of the first Aldermen appointed to the new Kingston Council at its formation in 1964, and he was elected to be the new Mayor of Kingston for 1966.

We extend our sympathies to his daughter, and to his son, Dr. Alan Gooding, who graduated from Guy's in 1958.

F.M.S.

CORRESPONDENCE

Thomas Hodgkin

SIR,—In view of the remarks in Passim (2.4.66) about Thomas Hodgkin, perhaps I could remind you of the photograph of the grave of Thomas Hodgkin in one of the issues of the *Gazette* for September, 1956. The writer drew attention to the neglected condition of this grave somewhere in Palestine. It may of course have been remedied by now, but I do not remember seeing any further reference to the matter.

Yours, etc.,

G. L. DAVIES.

Oakfield, Hay-on-Wye,
Hereford.

STUDENT EDUCATION COMMITTEE

By Hugh Sturzaker

A year ago the Student Medical Education Committee was founded and now would seem to be a good time to look at the year's work, to mention what has been achieved, to examine our failings and to look to the future.

Structure and function of the Committee.

The committee consists of 14 medical students elected from different years of the course, and the Presidents of the Students' Club, the Pupils' Physical Society and the Secretary of the Physiological Society are ex officio members. Most meetings of the committee have been open to all Guy's medical students, and much of the work has been done by sub-committees of up to three people, which have the power to co-opt non-members of the committee. The committee has worked closely with the departments and individuals concerned and has kept the Dean regularly informed about its activities. Progress reports have been sent to every medical student on two occasions, and now that the committee has at last been granted board space in the East Wing, it is hoped that medical students will be kept better informed of the committee's activities.

Achievements.

Nine reports have been produced and the committee has acted on many other items which did not necessitate a written report. Thus, arrangements were made for a porter to convey specimens from Hunt's House to the Clinical Pathology department, suggestions have been made for improvements in the clinical student laboratories—many of which have been put into effect—signing in for clinical lectures has been abolished (there has been no decline in attendances), a course in efficiency reading has been started, the first of occasional film shows at lunch-time proved popular, telephones have been installed in the College take-in rooms, and ophthalmoscopes can now be claimed for in students' instrument grants.

An annual series of five lectures has been instituted on contraception and psychosexual problems. It was given by Mr. Tomkinson and Dr. Stafford-Clark, and the speakers have played to a full house on each occasion. The Director of the Marriage Guidance Council gave a most interesting talk about his Council's work, and arrangements are in hand for students to obtain further information by means of week-end courses and tape recordings of mock interviews. The committee arranged with Dr. McEwan, Chairman of the South-East London branch of the Family Planning Association, for a group of students to visit four clinics in the area, and as a result it is now possible for all students during their midwifery appointment to attend two sessions at the Walworth Women's Welfare Centre to see something of the work carried out by the F.P.A.

A symposium to discuss tutorial systems was held last December, and the two main recommendations were that on entry to Guy's, all medical students should be allocated to "Directors of Study", and that there should be more small group teaching. The first of these proposals is soon to be instituted for pre-clinical students.

The committee has also produced reports on the teaching of Bacteriology, Pharmacology and Therapeutics, on the General Practice Attachment Scheme, and on a First Aid course. Many of the proposals in these reports have yet to be implemented, and this applies to the reports suggesting the establishment of a Medical Education Research Unit and a Learning Centre at Guy's. These last two reports contain more revolutionary ideas than the other reports, but in the past Guy's was in the vanguard of teaching methods, and it is to be hoped that Guy's will take the lead again. The whole of Medical Education is in a state of flux and it is vital that methods of learning and different forms of curricula are examined now, to decide which are the best, rather than leaving the establishment of a research unit until the form the curriculum should take has been decided and put into effect.

Failings.

Unfortunately, little of the committee's work has been connected with the pre-clinical period. This is mainly explained by the fact that soon after the committee's formation two of the pre-clinical representatives became clinical students, two gave up medicine, and very rarely did pre-clinical students attend the committee's meetings. The Committee could have publicised its activities better, and now it has its own notice board this should be rectified. Some members of staff intimated that the aim of the students in forming the committee had been to do less work. Nothing could have been further from the truth, for by improving communications between staff and students, the committee hopes to remove many of the present anomalies so that students will be encouraged to work harder and better. Finally the efficiency of the committee has not always been as high as it could have been in certain respects, but all these criticisms should be correctable if the members of the new committee are prepared to learn from the mistakes of their predecessors.

The future.

A glance at what has been achieved already by the committee should convince our critics that the formation of such a committee was necessary, and the plans for future work are sufficient to keep the committee busy for the foreseeable future. But even when these plans have been achieved there will still be a need for the committee's existence, for it is essential to provide a feed-back to staff from the students on all matters concerned with their education, for, being on the " receiving end ", the student is often the only person who is in the right position to make certain judgments. His job should not be merely to criticise, but to make sensible and considered remarks and suggestions so that his education and that of his successor may be improved, made more efficient and better for teacher and student in every respect.

The committee has been fortunate in having a core of efficient and hard-working enthusiasts, and their work has been greatly helped and encouraged by many members of staff, especially the Dean, who gave every support to its formation and who has been most willing to see members of the committee even at very short notice. Let us hope that the committee can do even better in the future, but this will depend on students giving it their full support by being prepared to work as members of the Committee and on all others being willing to give their opinions and help when they are sought.

Nominations for membership of the committee close on Thursday, 5th May. Elections will take place on Monday, 9th May, and the Annual General Meeting will be on Tuesday, 10th May.

REVIEW

LECTURE NOTES ON OPHTHALMOLOGY.

P. D. Trevor-Roper, II Edition. Blackwell. pp. 103. *Price* 16*s*.

The brevity of this book makes it eminently suitable for introductory reading prior to the ophthalmology appointment and for revision before finals. It is well illustrated in both colour and black and white (though one wonders if the rather poor quality of some of the former justify their inclusion.) The text reads well and is simple and explicit. In this edition there is an appendix on tropical ophthalmology that is concise and interesting, but perhaps a little too brief to be of much use.

In the main this book has much to recommend it, and it has few rivals in its price range. For those reluctant to invest in any book on such a limited topic, it is perhaps worth reiterating the author's concluding remark that " . . . . although ophthalmology is a small speciality, the whole field of medicine lies within its frontiers." And, indeed, there can be few easier ways of grasping the essentials of the subject than by reading this book.

F.D.

SPORT

There has been very little sporting activity in the last fortnight, partly because we are at present in the transitory period between winter and summer, and partly because of the atrocious weather which has played havoc with training and practices for the coming season.

The Rugby Club were invited to send a guest seven to the Ayrshire Sevens on April 17th. Unfortunately, Guy's did not perform too well after a 350 mile road journey. They lost 8—9 to Dumfries in the first round, Beacham and Edgar scoring the Guy's tries. Apparently Guy's took rather too long to settle down and were six points down after only a couple of minutes' play.

Last Saturday, Guy's entered two sevens in the Middlesex preliminary rounds at Beckenham. Guy's I beat the Bank of England 19—0, and Old Whitgiftians II 11—10, but lost to Sidcup 10—18 in the third round. Guy's II lost to London Scottish II in the second round, having earlier beaten Hong Kong and Shanghai Bank 5—3.

Because of the weather, the Cricket Club's opening match against Beckenham was cancelled. Prospects for the season will be discussed in the next issue. One new feature is a two-day fixture against the Birmingham medical students.

Tennis also suffered because of the weather, which is a great pity as the club has a much stronger fixture list this year and needs all the practice it can get.

The Athletics team has its first big event this week-end with the University of London Championships at Motspur Park. Guy's are the present holders and prospects for remaining so appear to be good.

DIARY

CRICKET.

April—Saturday, 30th. Lloyds Bank (A), 2.00 p.m.
May—Sunday, 1st. London Hospital (A), 11.30 a.m.
Wednesday, 4th. Wanderers (H), 11.30 a.m.
Saturday, 7th. Honor Oak (A), 2.00 p.m.
Sunday, 8th. Ashtead (H), 2.30 p.m.
Wednesday, 11th. Stoics (H), 2.30 p.m.

ATHLETICS.

April 29.—University of London Championships (Heats), 6.30 p.m. Motspur Park.
,, 30.—University of London Championships (Finals), 1.30 p.m. do.
,, 30.—Athletics Club Dance in Students' Club, 8.00 p.m.

REPORTS AND RESULTS

RUGBY FOOTBALL

"A" XV TOUR OF NORTH WALES, EASTER, 1966

Only six people had turned up when the "A" XV set off on Good Friday morning. Many hours later, after bouncing over the furrowed surfaces of the premier motorway and seeing endless lines of gleeful holiday makers crawling along Watling Street, Snowdonia, the sun and an Atlantic swell gave us a boost for the task in hand. No members of the side had arrived apart from the original six. However, a team of twelve finally assembled, but a couple of phone calls soon pressed three local lads to play.

The kick-off was delayed by an hour for their first game against Llandudno. The ground turned out to be a converted rubbish tip partially submerged. The team staggered on to the pitch faced by a fit looking Llandudno team, and from the kick-off charged into the attack, with Guy's substitutes playing in the centre positions and stand-off half.

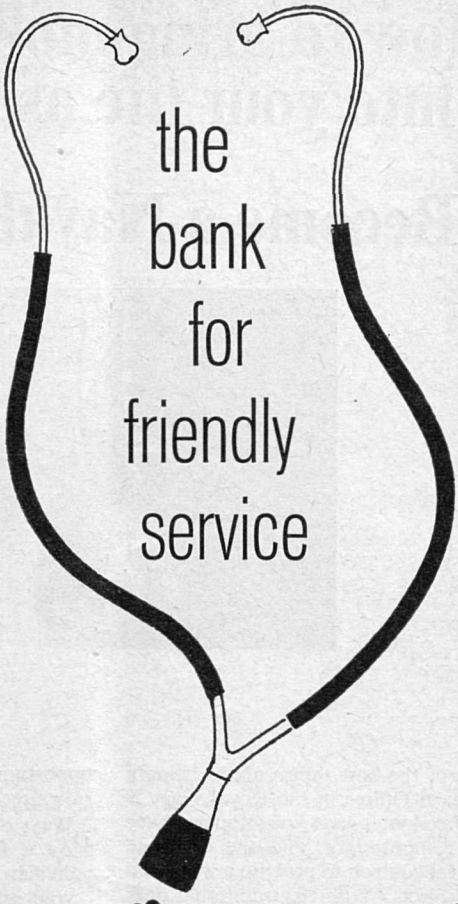
The first score came from Llandudno after fifteen minutes when they scored a try which was converted. However, Guy's forwards had gained control and were regularly heeling the ball back from the tight, loose and line-out. Near half-time Doyle opened Guy's account; from a loose maul he took a pass and galloped twenty yards round the full-back for a try, which Morris failed to convert.

In the second half Guy's got more on top with Dobson making some determined runs down the right wing. Doyle completed the scoring with another try scored from a quickly-taken line-out to give Guy's a 6—5 victory.

The teams then drove a couple of miles to a fine hotel in Deganwy to find the most comfortable changing room of their careers—the hotel lounge! But thirty naked men passing through the kitchens to the single outside shower must have surprised the staff more than a little.

A very pleasant evening was spent in the bar of this hotel and then the team returned to their own hotel via chip shops, etc.

The hotel manager suggested everyone to go to bed, which did not go down too well; and it was only the sight of the manageress in night attire—looking like an angel of wrath—that brought peace to the hotel.

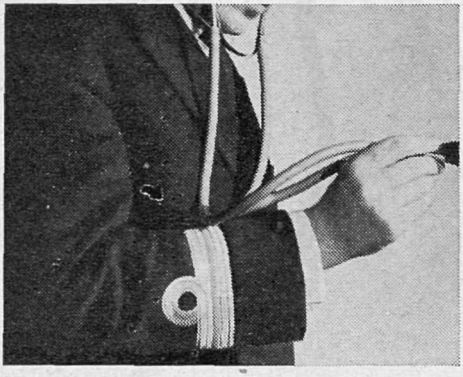


National Provincial

The Guy's Hospital Office, which is opened for your especial use, is under the management of Mr. A. C. Edwards, Southwark Branch, 10-14, Southwark Street, London, S.E.1, and enquiries will be welcomed.

How to bring more freedom into your life as a doctor.

Become a Naval Officer!



One of the best things about being a Medical Officer in the Royal Navy is the freedom it gives you. You can have the responsibility, and the complete clinical control, to practise a wide field of subjects – both the traditional ones and the new sciences, like nuclear, underwater and aviation medicine. You can also study for higher degrees, specialise and even aim for consultant status – all with the full support of the Royal Navy.

What about your pay and prospects? These are good. Your *starting* salary would be considerably higher than that of a civilian hospital registrar (with marriage and other allowances to add considerably to your income). Moreover, you can add in the varied, active, outdoor life of a naval officer – with its comradeship, world travel and very special status. You enter initially for a Short Service Commission – with the opportunity of a Permanent Commission after 1 year.

3 Ways of Entry

1 As a fully registered doctor; any civilian experience counts towards your seniority.

2 During your pre-registration year.

3 As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

If you would like more information, write to the address below, giving details of your age and qualifications. A personal interview can be arranged if desired.

The Medical Director-General of the Navy, Dept. 26DN3, Empress State Building, London, S.W.6.

Royal Navy

The next morning was spent either sleeping or just laying around, before the afternoon's game with Bangor. Somehow all five cars found the ground punctually, and Guy's kicked off with Fleming-Jones substituting for Morris. The Guy's forwards soon had things going their own way, but the threequarters were not tackling very well and this resulted in Guy's being 0—6 down at half-time.

The second half was disastrous. Guy's backs were not tackling, and, with Bangor scoring four more tries, all of which were converted, Guy's lost 0—26. Guy's backs never looked like scoring.

In the club house afterwards were a couple of old Guy's blues who entertained the team admirably. From here the members of the team dispersed for more leisurely activities after a very enjoyable week-end.

D. A. EDGAR

HOCKEY

FOLKESTONE INTERNATIONAL HOCKEY FESTIVAL, EASTER, 1966

Once again the Hospital Hockey Club were fortunate enough to be represented at the Easter Hockey Festival at Folkestone, which this year was celebrating its Diamond Jubilee.

We arrived at our hotel at lunchtime on the Friday, and after a little light refreshment, we played our first game against Old Dragons. This was not one of Guy's better displays, but nevertheless, the defence did extremely well to hold a very strong and experienced opposition to only four goals. We were unable to discover whether or not the Old Dragon's goalkeeper was as good as his colleagues. The evening was spent in the customary manner, the team making their way to bed at various times between 11 p.m. and 4 a.m. Those who went to bed early were somewhat less fortunate than those who departed later: An honourable member acquired the master key—surely, having now gained it three years running, he should be allowed to keep it—and as a result several dormant individuals were forcibly persuaded to spend the rest of the night on the floor.

The next day all matches were cancelled because of torrential rain, but conditions after lunch had improved sufficiently to allow visits to golf courses and dodgems. The early part of the evening was spent entertaining the West German side, Bremen, whom Guy's should have played in the afternoon. It was a great shame that this game was cancelled as they are reputed to be one of the best sides in Germany.

The abundance of signs around Folkestone at this time ensured that the evergreen sign hunters were not to be disappointed. Two cars reaped rich harvests, one of which was lucky not to have a summons to the effect of "failure to report an accident" added to its collection.

The weather cleared on Sunday and a match of high standard was played against Old Canterburians. This was one of Guy's better performances, but neither defence yielded. It was good to see Keith Haynes, last year's captain, playing again, this time for the opposition. Later on that evening a magnificent gesture was made by one of Guy's wing-forwards: it was reported that he visited many of the more illustrious teams at the festival assuring them that Guy's were undoubtedly one of the better sides this year. His attempts to perform on the field the next day would leave this matter in some doubt. However, the rest of the side fared little better. By this time the rain had returned in full force, and the game, against Havant, was reduced to 20 minutes each way due to the state of the pitch. The combined state of pitch and players made serious hockey impossible and hence it was hardly surprising that neither side was able to locate the opposition's goal. Havant tried desperately hard and it was only the amazing agility of the Guy's goal-keeper that kept them out.

The results—drawn 2, lost 1, were not as satisfactory as we might have wished, but the fact that we failed to score a single goal was particularly disappointing. Nevertheless, an extremely enjoyable week-end was had by all.

Team: (from) S. B. Rear; R. Kendrick, M. Vellacot, M. Horrocks; J. K. Crafts, C. A. Brooks, D. C. E. Loader; S. Cripps, D. Steer, M. I. Appleby, R. S. Carruthers, C. Pearson, P. Brown.

Kitty master: K: Lockhead.

R. S. CARRUTHERS

LADIES' HOCKEY

This has not been the satisfactory season we had hopes of in October. Despite a promising fixture list and an influx of enthusiastic freshers we have played relatively few matches. Much to the disappointment of our keen and willing players, cancellations have, in the main, been due to opponents failing to raise a team. Thus, with little practice, on the occasions when we played we met with little success.

Our performance in the Cup matches improved slightly on last year. In the University Cup we lost 4—1 to Imperial College. In the U.H. Cup we lost 4—2 to St. Thomas's in the semi-final.

At the University trials, Ann Collins was selected for the 2nd team, and Sue White for the reserve team.

Ann Collins, Mary Fortnam, Kate Thorne and Sue White have played for the U.H. team during the season.

At the Annual General Meeting in December the retiring secretary, Linda Barnett, and captain, Lesley Sayes, were replaced respectively by Ann Collins and Mary Fortnam.

Through the columns of the Sports section of the Gazette we would like to express our thanks to the Men's Hockey Club for their co-operation for use of the pitch and help in providing umpires for our Cup matches.

MARY FORTNAM

LAWN TENNIS

Although appalling weather conditions have curtailed practices, the Club is hoping to continue last year's success when 20 out of 24 matches were won. To record such a high proportion of wins this year will not be easy as a number of matches against strong clubs have been added to the fixture list.

During the next three months the Club will be playing three matches most weeks, which means that members of the second team will get a number of opportunities to play in first team fixtures. In addition to the serious matches, mixed matches are being arranged and, judging by the enthusiastic response shown by the ladies, the more social aspects could do with further expansion.

All of last year's Cup winning VI are eligible again this year so that the prospects for the Hospitals' Cup are good. However, none of the hospitals have yet assessed this year's intake of freshmen, and since two good players can improve a side enormously, Guy's must guard against over-confidence.

Although the fixtures and number of players will probably prove satisfactory, the state of the courts is more worrying. At present two of the grass courts are incorporated into the rugger pitch during the winter, and no groundsman can hope to provide a flat surface after such treatment. The hard courts are in extremely poor condition, and Guy's are having to borrow courts for the early matches. It seems incredible that the hospital, which has

won the tennis cup more times this century than all the other hospitals put together, should have to manage with such conditions. Only by improving their facilities will Guy's be able to keep fixtures with good clubs and thus maintain and further improve their standards.

JOHN NEWMAN

ATHLETICS

Preview of the 1966 Season

The athletic club will be faced this year with the major task of defending its titles as University and United Hospitals champions. A number of members have recently qualified and although some of these are still eligible to compete, the success of the team will depend this year on recent arrivals at Guy's such as Allen Ross, Mike Cheesborough, G. Waterhouse and others.

The first important match of the season is the University of London Championships, to be held at Motspur Park on the 29th (Heats) and 30th (Finals) of April. It is hoped that more support will be given this year to the team by non-competing Guy's students and staff.

Sports Day has been fixed for the 11th of June at Honor Oak Park, at 2.30 p.m. A dance will be held later in the pavilion at 8.0 p.m. and we hope that it will meet with as much success as last year. The United Hospitals' Championships will precede Sports Day and have been arranged for the 1st and 4th of June at Motspur Park.

A larger than usual number of fixtures have been arranged for the month immediately preceding the United Hospitals' Championships and it is hoped that this will help members in reaching peak conditions for this very important match. As a rule details and selections for the week's matches will be put up on the Athletic Club's notice board in the East Wing on Monday morning and members are requested to pay special attention to these notices.

P. M. J. DOMAINGUE.
(Secretary G.H.A.C.)

SAILING CLUB

1st VIII

Bow N. Pinckney
2 R. Mandeville
3 P. Burton
4 J. Osborne
5 M. Mace
6 A. Hodgekinson
7 J. Pook
Stroke R. Forrest
Cox T. Kirk

Rowing during the Easter Term is by tradition the time for hard training and building up crew spirit for the Summer Regattas. Unfortunately, however, some of the better oarsmen at Guy's had to give up rowing because of exams, and so a new crew was chosen. This was based upon last term's highly successful 2nd VIII, and so brought some considerable strength and weight into the crew, but also a certain amount of clumsiness and weird rowing styles.

The programme for the term was two long outings a week, culminating in the Head of the River Races. The traditional third outing of the week, held on Sundays, was scrapped owing to the fact that no coaching could be found for weekday or Sunday outings. Not having an uncoached outing was thought to be better than having it—in inevitably foul weather, with its dangers to crew morale. In order to offset this loss a larger than usual programme of circuit and weight training was held in the gymn. Although building up fitness, this did not solve any problems in crew and personal rowing techniques which are the most important aspects of training any crew.

However, training for the Heads went fairly well, though badly needed outings were lost owing to crew members other commitments and illness. The result of this was a crew that seemed to have strength, and probably enough stamina for the full Mortlake to Putney course.

U.L HEAD (Mortlake to Putney).

After having had no outing for the previous 1½ weeks, we arrived at the Boat House feeling somewhat apprehensive. The start was fairly fast, and the crew settled down striding at about 32 strokes/min. No particularly opposition was felt from the crews ahead or behind. However, at the finish we were catching the crew ahead, and were well away from that behind. The row seemed reasonable, though there was some rushing and splashy bladework.

Result: 12th (last year 18th).
Time: 19.56 mins.

BEDFORD HEAD

This was held three days later on the River Ouse at Bedford. The "spade" blades had just arrived back from repairs, and after a short practice outing in the morning everyone was pleased with them. Guy's started 12th, being the last crew in the 1st division. Although rowing off from the start reasonably, and gaining on the crew in front, some rushing set in as we reached the Brewery bend, from which the crew did not recover. A vast amount of cheering for Guy's on the last half of the course was very heartening but did not make up for the lack of competition from other crews.

The row was not good and once again bladework was ragged, but we learnt how not to row—the hard way. The day's visit was otherwise enjoyable and a welcome change from rowing at Chiswick.

Result: 29th (last time held, 1964, 20th)
Time: 8.41 mins.

READING HEAD

We arrived there on a good day for a change and immediately had a practice outing. Since Bedford we had swapped boats with the 2nd VIII, gaining a lighter boat. The effect of this and a shake up on the previous Wednesday had a good effect on the crew, which was rowing noticeably better.

The race began with Thames R.C. Vth VIII in front and a school crew behind. A good start and stride made the boat run well, and soon we had caught Thames. With the aid of a "ten" we were level, held their replying "ten" and soon Guy's were ¾-length up. However, the power of our stride weakened a little, and the opposing cox cajoled his crew into even greater efforts, losing us ¼-length. A deadly earnest battle began and continued to the finish for a further good 12 minutes rowing, both crews finishing level.

This was felt to be a good row, and at a high rating for us. If we had been able to stride out with a little more control the crew would have pulled ahead convincingly. This was a good lesson for us, and also valuable experience for Tim Kirk who coxed well.

Result: 97th (last year 121st).
Time: 15.53 mins.

TIDEWAY HEAD (Mortlake to Putney).

The Race was held late in the afternoon due to the ebb tide, but was a good event with fine weather.

Guy's went off very steadily from the start rating only about 30 strokes/min. This gradually built up into a very good stride with a great deal of power in it. The strategy was to go flat out from the Bandstand to the bend at Putney and then finish as best we could. In fact the boat was running superbly at the Bandstand, and soon we were passsing two crews. Unfortunately one of them closed in on us and there was a clash of blades resulting in John Osborne's blade being broken. He was furious, but rowed on as well as he could.

Guy's still passed both other crews rapidly, and so honour was satisfied. This incident rather unsettled the stride, and was not helped by a crab. However, with a few "tens" and shouts of encouragement Guy's recovered and settled down to a hard row. At Hammersmith Bridge a good "ten" was followed by some rather rough rowing, due to some panic in the engine-room. Fortunately the stride held, and although rather scrappy, Guy's finished overlapping the next crew ahead.

Result: 162nd (last year 204).
Time: 20.40 mins.

The achievements of the term were fair, but with a crew of good potential the results would have been much better if coaching was readily available and if three outings a week had therefore been practical in training. Also levels of enthusiasm in the crew varied, and although most members were very keen, it was still necessary to remind members to train regularly. This should not be so amongst those capable of rowing seriously in the 1st VIII, and as a result some crew change will occur before the Inter Hospital Bumping Races in May.

P. J. BURTON,
Captain of Boats

HOSPITAL INFORMATION

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Clinical Pathology**, from 16th May to 30th September, 1966, in the first instance, renewable. Forms of applications are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be lodged with him not later than **7th May, 1966.**

GUY'S HOSPITAL

JUNIOR STAFF APPOINTMENTS, 1966-67

Applications are invited for the following appointments to the Junior Staff of Guy's Hospital, commencing on 1st October, 1966, for the session 1966-67. Forms of application are obtainable from the Superintendent and should be lodged with him not later than **14th May, 1966:—**

Anaesthetics	
Senior Registrars	3
Registrars	3
Registrar	*1
At St. Olave's and New Cross Hospitals	
Registrars	2
Cardiology	
Senior Registrar	1
Junior Registrar	1
Child Psychiatry	
Senior Registrars	2
Registrar	1
Clinical Pathology	
Senior Registrar	†1
Registrar	3
Registrar	‡1
Registrar (Haematology)	1
Dermatology	
Registrars	2
Diagnostic Radiology	
Senior Registrars	2
Registrars	2
Trainee Registrars	2
Ear, Nose and Throat Surgery	
Senior Registrar	**1
Registrars	**2
Endocrinology and Radioisotopes	
Registrar	1
G.U. Surgery	
Senior Registrar	1
Medicine	
Senior Registrar	1
Registrars	3
Junior Registrars	4
At New Cross Hospital	
Registrar	1
At St. Olave's Hospital (from 22nd October, 1966)	
Registrar	1
Neurology	
Senior Registrar	1
Registrar	1
Obstetrics	
Senior Registrar	†1
Registrar	1
Ophthalmology	
Senior Registrar (part-time)	1
Registrars (part-time)	2
Junior Registrar	1
Orthopaedics	
Senior Registrar	†1
Registrar	1
St. Olave's Hospital	
Registrar	1
Orthopaedics and Casualty	
Registrar	1
Paediatrics	
Senior Registrar	1
Registrar	*1
Physical	
Senior Registrar	†1
Registrar	††1
Psychological Medicine	
Registrars	3
Radiotherapy	
Senior Registrar	1
Registrar	1
Surgery	
Senior Registrars	2
Registrars	2
Junior Registrars	‡‡4
Thoracic Surgery	
Senior Registrars	2
Registrar	1
V.D.	
Registrar (part-time)	1

***Registrars under the Exchange Scheme**

These appointments are under the Exchange Scheme and will be made jointly with the South-East Metropolitan Regional Hospital Board and Guy's Hospital, in the following subjects with a two-year tenure of the posts. Applicants will be expected to spend one year at Regional Hospitals in the Groups mentioned:—

Anaesthetics—Brighton and Lewes Group.
Paediatrics—Brighton and Lewes Group.

†Senior Registrars under the Exchange Scheme

These appointments are under the Exchange Scheme and will be made jointly with the South-East Metropolitan Regional Hospital Board and Guy's Hospital, in the following subjects with a four-year tenure of the posts. Applicants will be expected to spend periods as stated in the Regional Hospitals in the Groups mentioned:—

Clinical Pathology—Lewisham Group (two years).
Obstetrics and Gynaecology—Bromley Group (two years).
Orthopaedic and Traumatic Surgery—Medway and Gravesend Group (two years).
Physical Medicine—Bromley Group (two years).

‡Registrar in Clinical Pathology

This appointment will be made jointly with the South-East Metropolitan Regional Hospital Board and Guy's Hospital, for a three-year period, half of which will be spent in the Brighton and Lewes Group.

Registrars in Ear, Nose and Throat Surgery
Appointment to these posts may involve spending one year at Lewisham Hospital under an Exchange Scheme with the South-East Metropolitan Regional Hospital Board.

††**Registrar in Physical Medicine**
This appointment will also involve duties at New Cross and St. Olave's Hospitals on a day-to-day basis.

‡‡**Junior Surgical Registrar**
Two of these appointments will be two-year rotating appointments with duties for six months at the Maudsley Hospital. Appointment for one year in the first instance—renewable.

GUY'S HOSPITAL MEDICAL SCHOOL
JUNIOR STAFF APPOINTMENTS, 1966-67

Applications are invited for the following appointments to the Junior Staff of the Medical School for the session 1966-67, commencing 1st October, 1966. Forms of application are obtainable from, and should be lodged with, the Dean, not later than **14th May, 1966.**

Chemical Pathology
Anderson Demonstrator 1
Anatomy
Junior Lecturers 4
Junior Lecturer (part-time) 1
Medicine
Pre-Clinical Tutor 1
Junior Lecturer 1
Poulton Fellowship 1
Pharmacology
Junior Lecturers 2
Physiology
Junior Lecturers 3
Surgery
Lecturers 3
Student Health Service
Assistant to the Director (part-time) .. 1

Applications are invited for the following Fellowships and Studentships. Applications should be made not later than **14th May, 1966,** on a form to be obtained from the Dean, Guy's Hospital Medical School.

The Adrian Stokes Memorial Fellowship
The Fellowship is open to qualified Medical Practitioners or Graduates in Science, in Pathology, or Bacteriology. Applicants must be anxious to carry out further study in Pathology, or Bacteriology in any of their branches. The Fellow is required to carry out this study during a period of not less than six calendar months in his year of tenure, at a University, School or Hospital or other institution, subject to the approval of the School Council, except the School in which he has received his medical or scientific education. The Fellowship is of the value of approximately £460.

The Arthur Durham Travelling Studentship
Candidates for the Studentship must be registered medical practitioners who have studied at Guy's Hospital Medical School. The Student is required to proceed abroad for the purpose of carrying out such investigations as may be approved or directed by the Board of Electors, and shall undertake to reside continuously abroad for a period of not less than six months. The Studentship is of the value of £210.

The Francis Lett Scholarship
Candidates for the Scholarship must have studied at Guy's Hospital Medical School. The Scholarship may be held by itself or in conjunction with other Studentships. The purpose of the Scholarship is to enable the Scholar to obtain experience in other Medical Schools or Hospitals, at home or abroad. Candidates must submit their proposed programme with their application. The Scholarship is of the value of approximately £750.

GREENWICH DISTRICT HOSPITAL
Miller General Wing, Greenwich High Road, S.E.10. (189 beds). **House Physician,** vacant 1st June. Six months appointment. National salary and conditions. Write with testimonials /references to, the Group Secretary, G. & D. H.M.O., Greenwich District Hospital, St. Alfege's Wing, Vanbrugh.

PASS LISTS

COLLEGE OF PATHOLOGISTS
Part 1 Primary
R. B. Huddy R. R. Millis
C. J. Hunter-Craig

ROYAL COLLEGE OF SURGEONS OF ENGLAND
Primary F.F.A.
T. E. J. Healy P. B. Wemyss-Gorman

PERSONAL

Peace and silence, 3½-hours from Paddington. Exmoor, large 16th Century farmhouse. All mod. cons. Some service. Not August. Also single roomed cottage. Austerely furnished. £1 0s. 0d. p.w. Box No. 50.

CHANGES OF ADDRESS

BEECHING.—Brian and Mary Beeching, returned to 12, Trinity Trees, Eastbourne, Sussex.

EMBERTON.—Dr. F. C. Emberton, to 27, Crescent Wood Road, Dulwich, London, S.E.26.

FIRTH.—Drs. Peter and Jean Firth, to The Registrar's Flat, St. George's Hospital, Tooting Grove, London, S.W.17.

FRANCIS.—Major and Mrs. P. C. Francis, R.A.M.C., M.R.C.O.G, to the British Military Hospital, Hanover, B.F.P.O.33.

BIRTHS

MEANLEY.—On 19th July, 1965, at the Norfolk and Norwich Hospital, to Elizabeth (née Quick, S.R.N.), and Dr. Jeremy Meanley, a daughter, Juliet Elizabeth.

TILLER.—On 20th April, 1966, to Elizabeth (née Manley) and Eric Tiller, a son, Matthew John.

WOODMAN.—On 19th April, at the Norfolk and Norwich Hospital, to Jackie (née Decocq-Conti) and Michael Woodman, a son, a brother for Philippa.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

MARRIAGE

ISAACSON—TOWNSEND.—On March 26th, quietly in London by Lord Soper, Keith Geoffrey Isaacson and Jennifer Rosemary Townsend.

DEATHS

IRISH.—On April 14th, 1966, suddenly, David Herbert Irish, M.B., B.S., D.A., of Ivel House, Shefford, Beds.

MUSGROVE.—On April 17th, 1966, suddenly while on holiday abroad, A. Hugh Musgrove, F.F.A.R.C.S., D.A., of New Sarum, Llandaff, Cardiff.

EDITORS A. E. RAYNES and M. F. D'SOUZA
SPORTS CORRESPONDENT G. E. RATCLIFFE
FORTNIGHTLY TWO SHILLINGS VOLUME 79 NUMBER 2029

GUY'S HOSPITAL GAZETTE

PASSIM

Not the Answer

The Government, choosing to ignore its prices and incomes policy, has accepted the recommendation of the Review Body on Doctors' and Dentists' Remuneration. Perhaps the most significant aspect of the recommendations is not the increase in salaries itself but the redistribution of incentives. In this way the Review Body has attempted to make general practice more attractive but, in fact, has done little more than recognise the volume of work of the general practitioner against the increased cost of living and recommended that he be paid more rationally. The difficulties in general practice will not be solved by built-in incentives in remuneration schemes. The problem is bigger than this and the recommendations will not stave off the impending crisis in the Health Service but may invite complacency in approaching the problem. This may be disastrous, for there is still urgent need for more extensive planning if even the present standards of health in this country are to be maintained.

The British Medical Association is being fatuous by assuming its stand of "bitter disappointment" over the timing of the G.P. awards. It should count its blessing that the Government conceded so much in direct conflict with its own economic policies. The efforts of the B.M.A. might be used more rewardingly if it concerned itself with future planning of general practice rather than let itself drift into the impending chaos of a Health Service which has had little fresh constructive thought since its inauguration.

Similarly in the sphere of hospital practice, the recommendations of the Review Body cannot be accepted as a solution to the problems. The plight of the junior hospital staff has been little more than acknowledged. Senior housemen have been given a rise of approximately tenpence an hour, making their income still less than that of the average labourer, while it remains almost economic suicide for a registrar to get married. Hours of work, housing, moving allowances, conditions of work, equipment and short staffing have all been swept under a thread-bare carpet.

There is a steadily increasing flow of medical graduates leaving the country in the face of an existing shortage of manpower, and the Review Body could do little to stop it. Voices which express the opinion that "we went through it, why shouldn't you" do nothing but increase the flow. While such attitudes exist there can be little hope for an enlightened approach to the problems of hospital service.

Not Observing

On the academic second floor of New Guy's House lurk the largely forgotten observation domes. Most clinical students are aware of them but the faces that occasionally peer down, hands wiping away breath condensation, are those of the curious rather than of the studious. Unofficial audience rating surveys reveal pre-clinical students—"Let's see what's on at the theatres, chaps"—a sprinkling of dental students, P.T.S. or first-year nurses, and here and there a clinical medical student.

Perhaps here lies the fault. Were he or she termed a clinical surgical student, his plight, grown in the mass desertion of the domes by clinical students, might be recognised, if not yet, palliated or perhaps cured. For apart from the dresser who is fortunate enough to be "assisting" the surgeon, few of the others on the firm are able to follow, let alone see the operation. Indeed, this respect for the functional confines of the theatre and the dangers of hoards of students inadvertently de-sterilising trolleys and drapes was presumably the incentive for building the domes. Yet still the firm is expected to be present in the greater part, and still the domes are not utilized by surgical teachers.

If the microphones were deliberately switched on, students on the firm and others seeking surgical knowledge could look straight down on the operating field and be *told* what is being done. They would be out of everyone's way, cut down laundry bills, be less liable to develop cervical strain through their efforts to see the knife in use and less likely to suffer the effects of postural hypotension induced by boredom and obvious lack of theatre chairs. Long lists and operations which for one reason or another do not make much teaching time available do certainly occur but are not the rule; in these a teacher could be present in the dome itself. The fine reputation of surgery in this teaching hospital could be better passed on to those who study here if at least some operating sessions were to become more educational rather than a spectacle in the nature of a badly edited silent film with irrelevant orchestral accompaniment.

"Seeing is not observing," said the Seer.

Medicine and Internationalism

> "Without arrogance we now see, as only a few saw previously, the special responsibility of science and medicine. Their strength rests in their essential internationality—not quite to be found in any other human endeavour. There are many religions, but there is only one science, and only one medicine."

These words were taken from the concluding address of Professor Alexander Haddow, at the Third Conference on the Pathogenesis of War, held in Cambridge in 1963. They sum up the realisations of many medical men today and give the reasons behind much of the practical idealism that makes the profession such a challenge in the modern world.

On the 25th of this month the Pupils' Physical Society is following this train of thought by holding a Symposium in honour of Thomas Hodgkin on "Medicine in International Co-operation", the programme of which is being printed in this *Gazette*.

A very significant part of this programme is the final half on "World Population Control" and "The Effects of Imposing Medical Care". All too often serious consideration of these has been only touched on and doctors with the same presumptions as missionaries have moved into underdeveloped countries in quest of doing good. They have indeed saved lives, albeit at the merest subsistence level, but they have not provided concurrent means for birth control. The consequence of these actions are all too well known and the drastic increase in the numbers of sick and starving have become far more than existing medical manpower can manage.

The need today, however, is for a still more international attack upon this problem, though with much more planning and foresight than in the past. Britain and the British medical profession cannot afford to remain wrapped up in so many domestic issues. Indeed, as has been suggested, we might find the answer to those problems of national purpose which crumbled with the Empire, in this very field of co-operative internationalism.

Professor W. V. Mayneord, C.B.E., D.Sc., F.R.S., will deliver the Fison Memorial Lecture in the Physiology Theatre on Tuesday, 24th May, at 5 p.m. His subject will be "Radiation and Health".

Mr. P. S. Firth has won the Gold Medal in the M.R.C.O.G. examination. Last year this medal was won by another Guy's man, Mr. T. R. Cullinan.

In February of this year we announced in Passim our intention of commencing a new Nursing News section. In this issue we are beginning this section with Sister E. A. Malpas as our Nursing correspondent.

GUY'S DIARY

MAY			
16th	M.	1.00	Dr. M. C. JOSEPH. A Case for Stosstherapy.
17th	Tu.	1.00	Mr. R. O'NEIL. "Oral Infections—Acute and Chronic".
		1.00	Dr. KENDALL. "The Diagnosis of Arthritis".
19th	Th.	1.00	Dr. A. J. ROSIN. Clinical Lecture. "Diagnostic Difficulties in the Elderly".
		5.00	Psychological Society. "Death", by M. E. PEMBREY.
20th	F.	1.00	Dr. SCOTT. Clinical Lecture.
23rd	M.	1.00	Dr. McARDLE. Clinical Lecture.
24th	T.	1.00	Dr. MOYNAHAN. Clinical Lecture.

Mr. MURRAY FALCONER will conduct the Neurosurgical Round at 5 p.m. on Thursday, 19th May.

Clinico-Pathological Meeting: There will be no meeting in May because of the Whitsun holiday.

RECENT ADVANCES IN THE BIOCHEMISTRY OF SCHIZOPHRENIA

by

J. R. Smythies

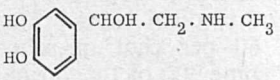
Department of Psychiatry, Edinburgh University

For the last 50 years, research workers have searched diligently for some biological disorder in schizophrenia without, however, until very recently, any result. It is generally agreed that the aetiology of the neuroses may most profitably be sought in psychological and environmental factors. It is widely thought, however, that the major psychoses, schizophrenia and manic-depressive psychosis, are associated with some inborn error of metabolism. This is not to deny the importance of psychological factors in these diseases as well, but these may be part causes modulating the development of the underlying biochemical disorder. The factors that have led people to suspect that schizophrenia is based on a biochemical disorder are as follows. Firstly, there is good evidence that there is an important genetic factor in the illness. Secondly, no discoverable psychological pre-disposition or factors can be found in at least half the cases that come to the clinic. Thirdly, we now know two conditions where a condition clinically indistinguishable from a paranoid schizophrenic psychosis is produced by a physical agent, i.e., temporal lobe epilepsy and chronic amphetamine addiction.

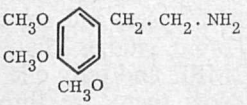
The early years of research work on the biology of schizophrenia was conducted on purely empirical lines. No hypothesis as to any possible causation was made, and people merely used the techniques familiar to them at the time. They measured liver function, adrenocortical function, blood glucose, etc. without however, achieving any results. The small but noticeable progress achieved over the last ten years has depended on the construction of several specific biochemical hypotheses. The clue to this has lain in the chemical formulae of the so-called hallucinogenic or psychotomimetic drugs: It has been known for a good time that drugs such as mescaline and LSD cause a psychological state that has some features in common with certain cases of acute schizophrenia. That is not to say that the conditions are identical. Nevertheless, there are many similarities

between them, and many of the differences may be accounted for by the very different environmental situations in such cases—particularly as it has been shown that the form of the mescaline psychosis itself is strongly affected by the nature of the particular environment at the time. Thus, we can conclude that there are sufficient similarities between the drug induced state and the natural illness to make it worthwhile enquiring more closely into the mechanism of action of the hallucinogenic drugs, with particular attention to the possibility that some compound like them might be produced by some aberration of metabolism.

The first hallucinogen to be discovered was mescaline, and if we look at its formula



Adrenaline



Mescaline

we see that it is a close chemical relative of adrenaline. The main changes are that an extra group has been added to the ring and that the hydroxyl groups have been replaced by methoxy groups—that is, they have been *methylated*. On this basis Osmond, Harley-Mason and I suggested in 1952 that the biochemical fault in schizophrenia might be some abnormality in adrenaline metabolism whereby compounds such as dimethoxyphenylethylamine (or DMPE for short) might be produced and might exert toxic effects on the brain, thus precipitating the psychosis (Osmond and Smythies, 1952). The location of the metabolic fault in the stress mechanism itself carries with it two further advantages. Firstly, it would explain the correlation of schizophrenia with stress of all kinds, particularly the type of psychological stresses that normally lead to the secretion of adrenaline. If there is a weak link in a biochemical chain this may only snap if a load is put on the chain. Similarly, a defective engine may work alright if run slowly, but may seize up as soon as any pressure is put on it. The second advantage of this hypothesis is that the production of toxic hallucinogenic compounds from adrenaline would lead to stress and so more adrenaline would be secreted, leading to more toxins and more stress, and so on. This hypothesis, therefore, is that adrenaline and other catechol amine metabolism may so be disordered as to produce possible hallucinogenic compounds such as DMPE.

It should be noted here that there are three important amines found in the brain that fit in with this hypothesis—two catechol amines—nor-adrenaline and dopamine, and serotonin. Thus, the metabolic fault may occur actually within the brain itself.

The next point to consider is whether there is any evidence to suggest that this hypothesis is either plausible or correct. When we published it in 1952 it was known that nor-adrenaline is turned into adrenaline by adding a methyl group to the nitrogen. But little was

known about the metabolism of these compounds thereafter. In 1957 it was discovered by Armstrong and Axelrod that the normal metabolic route is O-methylation; that is, a methyl group is put on one of the two oxygen atoms, taking us halfway to DMPE. Then in 1962, Friedhoff and van Winkle in New York reported that they had isolated DMPE from the urine of some 60 per cent of their schizophrenic patients and none of their normal controls. This paper aroused a good deal of interest and a number of other research centres took up this work. Of these, four reported that they had confirmed this claim, whereas two were unable to do so. The most extensive investigation was reported in October last year from Professor Clarke's department in Liverpool (Bourdillon et al, 1965). They investigated a very large number of schizophrenics, normal controls, patients with psychoses other than schizophrenia, pre-operative and post-operative cases, and some general medical cases. They showed in double-blind studies that about 60 per cent of schizophrenics excreted DMPE and only one out of some 300 of the various types of control. Now there are three main sources of error in any such investigation, as follows: (i) schizophrenics differ from normal controls in that they are frequently under stress, and the findings may indicate only a non-specific response to stress. In the Liverpool experiment this was controlled for by the other groups of patients, medical, surgical and psychiatric studied. (ii) The second source of error is drugs. The spot on the chromatogram might be some drug metabolite that happens to be like DMPE in its chromatographic properties They controlled for this by demonstrating the abnormal spot or "pink spot" in eight cases of schizophrenia off all drugs for two weeks "or more",[1] and its absence in twenty cases of other psychoses actually on phenothiazines at the time (Clarke, 1965). (iii) The third source of error lies in the possibility of contamination by dietary factors. It is notable here that the two groups mentioned who were unable to find DMPE in schizophrenic urine were the only two to use dietary controls. The first was Perry in Vancouver (Perry et al, 1964), who took his patients off all fruit and vegetables for a week before the test. Unfortunately, he did not then put them back on fruit and vegetables and test the urine again. The second worker (von Studnitz, 1965), however, did this. He demonstrated the presence of the compound and then put the patients on a pure glucose diet for three days, whereupon the spot disappeared.

Therefore, it seems probable that DMPE comes from dietary sources, and it is moreover unlikely in this case that the spot was caused by any phenothiazine metabolites.

Secondly, Shulgin (1965) has recently reported that DMPE in a dose of 600 mg. was without any effect on human volunteers. So it appears that the original idea that DMPE may be a psychotogenic agent in schizophrenia lacks support. Yet schizophrenics almost certainly excrete more of it than do controls. This suggests that schizophrenia may be associated with a failure to *demethylate* dietary DMPE and thus they excrete it to excess in the urine. It is

[1] Phenothiazines may continue to be excreted, however, for up to one year following the last dose.

known that the human organism can demethylate mescaline (Harley-Mason et al, 1958), and it is much more probable that a genetically determined illness is associated with the lack of an enzyme that should demethylate methyl groups. Inborn errors of metabolism are associated with absent or weak enzymes and not with new abnormal ones.

Now it is possible that a failure to demethylate DMPE is a sign of some basic disorder of transmethylation that may represent the actual genetically determined metabolic disorder in schizophrenia. The removal and addition of methyl groups is an operation of fundamental importance to the organism and any fault in it might be expected to have a serious effect on the activity of neurones. Is there then any evidence that methylation processes are disturbed in schizophrenia? In 1959 Kety and his co-workers published a paper reporting on the effect of feeding various aminoacids to schizophrenics (Pollin et al, 1959). The purpose of this experiment was to see the effect of the various amines derived from these aminoacids on the brain. So they were fed together with a monoamine oxidase inhibitor which prevents the breakdown of any amines so formed. Out of the dozen or so aminoacids they tested only two had any effect. The first, tryptophane, produced only a non-specific intoxication. However, the second, methionine, specifically made the schizophrenic symptoms worse. This effect of methionine has now been confirmed by two other groups with no contrary reports (Brune and Himwich, 1962; Spince et al, 1963), and by a further investigation by Kety's group (Park et al, 1965). Now methionine is an essential aminoacid and takes part in many of the body's biochemical reactions. It is significant that one of these is donating methyl groups. Methionine is, in fact, the major source of methyl groups in reactions where one methyl group has to be transferred to another molecule, as in the case of the normal metabolic breakdown of adrenaline. The fact that administering a methyl donor to schizophrenics makes their symptoms worse would support the abnormal methylation hypothesis of schizophrenia, if it could be shown that this was not due to some other action of the donor. To test this, Brune and Himwich (1963) fed schizophrenics with betaine, another methyl donor chemically quite unrelated to methionine. This also produced the same worsening of the schizophrenic symptoms indicating that it is the methyl donating property of these two agents that is responsible for this effect. Thus, we have three separate lines of evidence all pointing in the same direction. Firstly, it cannot surely be a coincidence that most of the hallucinogens (mescaline, psilocyn, dimethyltryptamine) are methylated derivatives of the cerebral neurohumours (dopamine, serotonin, noradrenaline). Secondly, there is very good evidence that schizophrenics excrete excess of a compound, probably DMPE, not found in normal urine. Thirdly, feeding methyl donors to schizophrenic patients makes their symptoms worse. These three facts all point to some disorder of methylation as being concerned in the aetiology of schizophrenia.

Another most interesting piece of evidence comes from the discovery in Belfast of the inborn error of metabolism—homocystinuria

(Carson et al, 1963). This is due to an abnormality of methionine metabolism whereby the normal route via cystathionine is blocked by absence of the enzyme cystathionine synthetase. Methionine metabolism is diverted to form homocystine which is excreted in the urine.

If methionine is fed to a patient, levels rise higher than normal in plasma and 5–8 times higher in urine than in normal controls. In the original family studied there were two mentally defective sisters with the illness. Their mother had very similar reactions to ingested methionine and was presumably a heterozygote. The point of interest here is that the mother and five of her close relatives were all apparently schizophrenics (1 brother, 1 sister, father, maternal uncle and aunt). Recently a second case has been reported from Baltimore of a patient diagnosed as a chronic schizophrenic who was later found to be suffering from homocystinuria (Spiro et al, 1965). These findings would suggest a more intensive study of these cases to determine if they were excreting DMPE or showed other disorders of transmethylation.

A second biochemical theory has been put forward by McIsaac (1961) who noticed that the pineal hormone melatonin is a close chemical relative of the hallucinogenic drug harmine. This lacked any experimental support until very recently when Greiner and Nicholson (1965) reported that the ordinary skin pigment melanin, is deposited to excess in many body cells of schizophrenics. Many reports have been made recently that overdosage with chlorpromazine leads to abnormal pigmentation, but Greiner and Nicholson examined post-mortem material taken before chlorpromazine was invented and these slides still showed excessive pigmentation. In humans pigmentation is normally decreased by melatonin, and the authors make the hypothesis that the normal route of synthesis of melatonin from serotonin is blocked owing to the congenital absence of a certain enzyme, e.g. o-methyl transferase, and so instead of melatonin, hallucinogenic compounds like harmine are produced.

An alternative hypothesis is that this excess melanin pigment may come from an abnormality of adrenaline metabolism, since melanin can also be formed from adrenaline.

This offers an interesting line of research if the claim of Greiner and Nicholson of excess pigment in schizophrenic cells can be confirmed. In this respect Shattock (1950) reported as follows in her classical review of the somatic manifestations of schizophrenia. "Pigmentation, light brown in colour, punctate, patchy or evenly distributed, was seen on the back, chest and abdomen of some female patients [36% of a series of 220 : 11.4% in a second series of 246], mainly, but not exclusively, in patients who also showed peripheral cyanosis. Pigmentation was never observed in male psychotics. In female patients, dark pigmentation of the nipple and areola was not rare [10.5%] and was sometimes striking, being darker than that frequently associated with pregnancy. The distribution of the areas of cyanosis and pigmentation did not correspond, and as these conditions also occurred separately, they may be unrelated. Pigmentation of the mucous membranes was never observed." However, some

epidemiological considerations must be met before these facts can properly be evaluated (Munro, 1965).

Research centres in various countries are actively pursuing this problem and current research is continuing along the following lines.

If schizophrenics are unable to demethylate dietary DMPE, then this substance could be fed to them and the amount of demethylation actually measured. Relatives of schizophrenics could also be tested in this way to determine if they might show some quantitative difference to normal controls.

Then again, it is probable that DMPE as an amine is metabolised in the body by monoamine oxidase and the corresponding acid would be excreted in the urine—in this case dimethoxyphenylacetic acid. Attempts to detect this compound in the urine are under way. Thirdly, a close examination needs to be made of the effects of feeding methionine on the excretion of methylated derivatives from this class of compound, and intensive biochemical studies should be carried out in cases of homocystinuria with and without schizophrenia. Fourthly, it is possible that schizophrenics may fail to demethylate other compounds than DMPE, and this should be tested for. Fifthly, it is still possible that DMPE and other compounds with perhaps potent hallucinogenic properties may result from the postulated disorder of methylation processes in schizophrenics and these should be sought for.

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NOTICES

The Pupils' Physical Society of Guy's Hospital

A Symposium in honour of THOMAS HODGKIN
on
MEDICINE IN INTERNATIONAL CO-OPERATION

WEDNESDAY, 25th MAY, 1966.

PHYSIOLOGY THEATRE, GUY'S HOSPITAL.

2.00 p.m. Introduction by the Chairman: Professor Butterfield, O.B.E., M.D., F.R.C.P.
2.10 p.m. " World Aspects." Dr. Goodman, C.B., M.D., F.R.C.P. (Chairman, U.K. Committee, World Health Organisation.)
2.40 p.m. Questions.
2.55 p.m. "Britain's Contribution." Dr. Dill-Russell, C.B.E., M.R.C.S., L.R.C.P (Deputy Medical Adviser, Ministry of Overseas Development.)
3.25 p.m. Questions.
3.40 p.m. " World Population Control." Sir Theodore Fox, F.R.C.P. (Director of the Family Planning Association.)

— T E A —

5.00 p.m. " The Effects of Imposing Medical Care." Dr. Barton, M.B.E., M.B., Ch.B. (Senior Lecturer, Ross Institute of Tropical Hygiene.)
5.30 p.m. Questions.

Reservations, if desired, may be made in writing to:
The Secretary,
Pupils' Physical Society,
Guy's Hospital.
M. E. PEMBREY (Organiser.)

Student Medical Education Committee Election Results

	Representative.
FIRST M.B.	R. SPEIGHT
FIRST YEAR SECOND M.B.	R. WAINWRIGHT
	J. MORSMAN
	M. WRIGHT
SECOND YEAR SECOND M.B.	J. HILL
B.Sc. AND DIPLOMA YEAR	J. O. SOUL
FIRST YEAR CLINICAL	N. CURRY
	W. HUGHES
SECOND YEAR CLINICAL	C. B. BROWN
	J. H. TRIPP
	M. A. SIMPSON
THIRD YEAR CLINICAL	D. S. ROBINS
	R. J. LEETE
	J. P. JAGO

OTHER MEMBERS
R. LANE (Students' Club), M. D'SOUZA (Physical Society) and the Secretary of the Physiological Society.

East Anglian Dinner, 1966

The Guy's Hospital East Anglian Dinner for 1966 will be held on Saturday, 4th June, at the Angel Hotel, Bury St. Edmunds, at 7.30 p.m. for 8 p.m. President: D. J. P. O'Meara, F.R.C.S., F.R.C.O.G. Guest of honour: J. C. Houston, M.D., F.R.C.P. If any Guy's man in East Anglia has not received notice of this dinner, but would like to come, would he please write to Dr. A. Batty Shaw, 41, Newmarket Road, Norwich.

Hospital Society

South Wales and Monmouthshire Branch

The fifteenth Annual Dinner was held at the Park Hotel, Cardiff, on Saturday, March 26th, 1966. Fifty-five attended. The chief guest of the evening was Professor Hedley Atkins, M.S., F.R.C.S., and Mr. J. L. Goodliffe was also a guest. An exciting game of Rugby was watched in the afternoon at Cardiff Arms Park when Wales gained a thrilling victory over France. The President, Mr. N. R. S. Harley was installed for the year 1966/67, and Dr. H. A. Thomas was elected as President-elect. The Society is now very flourishing, and one member described it as getting better every year. This year was an outstanding success, so members roll up and meet your friends and colleagues.

G. MORWENT BROWN,
Hon. Secretary.

CORRESPONDENCE

Hodgkin's Tomb

SIR,—Dr. Davies is rightly concerned with the condition of Hodgkin's tomb in Jaffa, but at the moment it appears to be well attended. Dr. William B. Bean visited the tomb in June, 1965, and has written a short note in the current Archives of Internal Medicine (Vol. 117, pp. 475-7), including a photograph showing it in its present condition.

Yours, etc.,
WILLIAM HILL,
Wills Librarian.

The Wills Library,
Guy's Hospital,
London Bridge, S.E.1.

Thomas Hodgkin

SIR,—In the correspondence (30.4.1966), attention is drawn to Hodgkin's grave. I feel sure that the Government of Israel, if approached by the hospital and relatives of Thomas Hodgkin, would assist in transferring his remains to be among his own people.

Yours, etc.,
HARRY N. LEVITT.

18, Daleham Gardens, N.W.3
(Hampstead 6822).

Smoking

SIR,—In his interesting article on smoking (30th April, 1966), Dr. Michael Bott seems to disagree with Prof. Eysenck's argument that extrovert smokers seek cortical stimulation from cigarettes, on the grounds that often they are also consumers of alcohol, which is a sedative. But surely it is not just the stimulation provided by the nicotine that must be considered. A cigarette gives the extrovert something to hold, something to suck, something to smell and taste, and an ever-changing pattern of smoke to gaze into. The stimulation provided to so many senses simultaneously, and so conveniently, must, of necessity, make cigarette smoking (irrespective of the nicotine content) extremely attractive to the extrovert.

Yours, etc.,
P. G. BUDDEN.

26, Aberdeen Park,
Highbury, N.5.

THE VALUE OF ART IN A PSYCHIATRIC HOSPITAL

by

Jan Glass

Department of Art Therapy, Warlingham Park Hospital

Art and psychiatry first came together through the interest and observations of certain psychiatrists of the mid-nineteenth century in the paintings by psychotic patients in Insane Asylums, as they were then called.

In 1876, a French doctor called Simon, published in Paris an illustrated book of paintings by his patients, in which he suggested that the pictures were not just the fantastic ramblings of diseased minds as they had hitherto been regarded, but had some relevance to the patients' particular problems and their desire to communicate.

In 1922, Hans Prinzhorn published a book in which the paintings by his patients were beautifully reproduced in colour. The paintings were now seen to be of interest from an aesthetic, as well as from a medical point of view.

By this time the artistic revolution which had started with Cezanne in the mid-nineteenth century was well on its way. The conception of a painting as a highly idealized representation of Nature was being challenged by artists all over Europe. The themes of the great Renaissance painters had become artificial and meaningless with constant repetition and imitation. Paris was taking its place as the centre of the modern movement in Art. A blaze of colour and a flood of expressive imagery proclaimed a new freedom and vitality which enabled men to express themselves, refusing to be hampered and stifled any longer by conventional symbols which no longer had anything real to communicate.

By 1907, Picasso was painting some of his most controversial works. Fifty years earlier they would almost certainly have been classified as psychotic and certainly as obscene.

It seems to me that when discussing paintings by patients, it is relevant to consider the changes in artistic expression that have taken

place in this century. Because these changes are bound to affect our judgment of patients' work, just as the patients themselves must be influenced by the kind of cultural environment in which their work is produced.

To-day we can appreciate painting as an essentially individual kind of communication, which may be a commentary by the painter on his way of life and his view of the world and other people. This sort of appreciation we may extend to the paintings by psychiatric patients whose work may not in any way be intended as Art, but is certainly concerned with communicating and expressing aspects of themselves and their way of life. Painting as a medium offers a unique way of doing this because it is so simple. A brush full of colour can outline the unhappiness of a lifetime.

The difference between a patient's paintings and the work of Picasso is that while Picasso is a master of pictorial organisation and completely in command of what is happening on the canvas, the patient is not.

The disintegrating forms and faces in the paintings by Francis Bacon have something in common with the portrait in Plate 1. This was painted by a doctor who was in hospital with a schizophrenic illness. In Bacon's work the disintegration of the image is deliberately contrived to make a certain impact upon us. The patient's painting is part of his experience of the disintegration of his personality.

A painter may portray a nightmare world and remain the sane observer of his own phantasies. The artist-patient who painted Plate 2, was portraying his actual experience of being in the world at that time.

A well-equipped Art Department in the charge of an experienced and professional artist is considered an essential in all progressive mental hospitals to-day. And now that the British Association of Art Therapists has been formed, a scheme for the specialised training for artists wanting to do this work is being planned. The Association now has over one hundred members, many of whom are qualified Art teachers with some years of experience in hospital work.

It is important for the Art Therapist, as well as having knowledge of the special problems in mental illness, to be a qualified and experienced Art Teacher, because he can assist with the technical problems with which some patients may be concerned, and also because, being an artist, he can distinguish between a facile and a genuine kind of expression and knows which to encourage. This is the difference between painting as an occupation and painting as a dynamic personal activity, and between good and bad Art teaching.

Art in a psychiatric hospital offers the patient an activity in which he is encouraged to make some kind of personal statement. The blank paper or the lump of clay may be the means of releasing pent-up feelings, of confronting personal problems, of relating himself

Plate 1

Plate 2

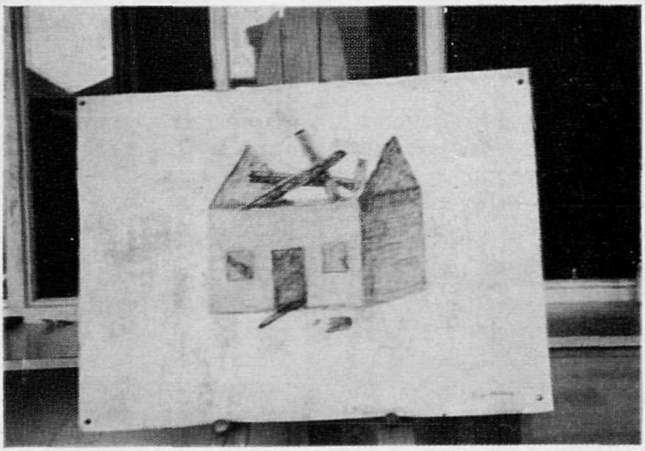

Plate 3

Plate 4

Plate 5

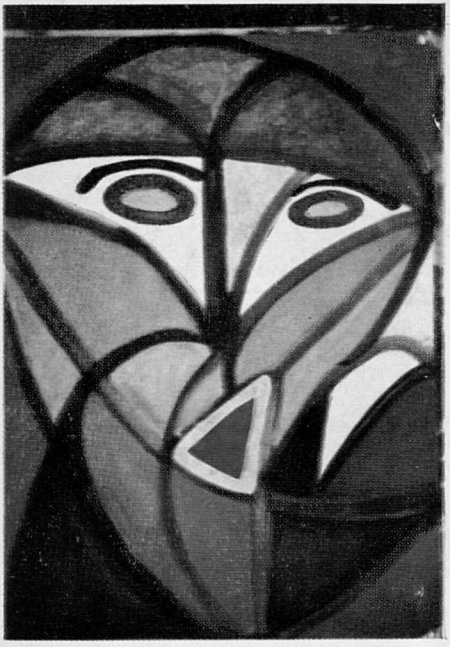

Plate 6

can control the symptoms of

schizophrenia for 2 to 4 weeks

Moditen Enanthate a long-acting injection of fluphenazine, is capable of controlling the symptoms of schizophrenia for up to 28 days with one intramuscular injection. Thus Moditen Enanthate can help to decrease the problem of relapse when the patient cannot be relied upon to take tablets. **Injections of Moditen Enanthate can substitute for phenothiazine tablets in the maintenance therapy of schizophrenics.**

Detailed literature on Moditen Enanthate injection and Moditen tablets (1mg., 2.5mg. and 5mg.) and elixir (2.5mg. per 5ml.) is available on request.

Moditen Enanthate : fluphenazine enanthate

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Moditen Enanthate

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to his environment. Whatever it is, the first painting will be the beginning of a relationship, a shared experience, a break-through.

In our hospital, most patients attend the Art Department on the advice of their doctors. This is usually decided at the patient's case conference. Reasons for suggesting Art Therapy will be various, but generally speaking, depressed, tense, and uncommunicative people are obvious candidates.

As painting or modelling are outside the everyday experience of most people, the first visit to the Art Department usually arouses a certain amount of anxiety. This may not only be true of patients, but members of staff, and visiting students, who may spend time in the department only if they are prepared to participate. Onlookers can be disturbing.

The most usual remark that the patient makes on entering the studio is "I can't paint", and in the context in which she means it, she is quite right. She can't paint objects so that they look "real", she knows nothing of perspective, tone values, or technique. She may feel completely at a loss. When she does begin, it is quite likely that she will paint a house. How she paints her house may be more revealing than she knows. It may be a small, black house in the centre of the page or right in the corner. It may have a fence all round it without any entrance, or a garden with flowers. It may have lots of large windows, or none at all. However it is painted, it will tell me quite a lot about her.

A patient I had recently, who was suffering from schizoprenia, painted a house in the middle of a big blue space. It seemed to be floating, detached, just as she was, unable to relate to anyone. As she got better, she covered the blue space with lines that she described as roads, so that it finished up like a map, with the house in the centre.

An elderly woman who had been treated for depression, painted a house just before she was discharged from hospital, apparently cured. It was an empty looking house without a garden. A black path leading from the doorway ended abruptly in space. It was a very simple, yet somehow impressive picture, and I kept it. Sometime later I heard that she had committed suicide.

A young man who had already been in hospital for two years with a schizophrenic illness, spent his first three weeks in the Art Department, painting coloured squares on the same piece of paper. He then asked for some black chalk, and drew a house. It was a derelict house, with the roof broken in (see Plate 3). This drawing was followed by a series of paintings in oils, most of them illustrating fairy tales about evil spells. These seemed to relate to his own feelings of being other than himself, of being turned to stone, or imprisoned in an enchanted world. Finally, he took a mirror (always present in the department), and painted a life-size and very life-like portrait of himself. Not long afterwards he was discharged and took

all his paintings with him to Ireland, where he was going to work on his brother's farm. In this case, painting played an important part in the rehabilitation of the patient. Before attending the Art Department, although very good at his work, he had resisted all attempts to move him outside the hospital, because he felt too frightened and insecure to cope with the outside world. Freud said that "There is a way back from phantasy to reality and that is Art"; in this case it seemed to work.

Catharsis through painting

A woman patient came into the Art Department in tears, she was white and shaking, and told me that she had just seen another patient smash a window and cut her wrists. This scene may have stirred unconscious fears and feelings of guilt about her own aggressive wishes. In any case, she was disturbed and unable to settle down. Finally she asked me whether I thought it would be a good idea to paint what she had seen. As she had suggested it, I thought she might try, and very soon she was absorbed in her work. She drew a broken window pane, a bleeding hand and tear-stained face. Seeming much calmer she said, "I've painted it out."

A depressive illness may be caused by the suppression of aggressive feelings. A patient may not be conscious of anything but love for the wife, parent or child around whom the most intense feelings are centred. In painting, the paper or board can be used as a safe area in which to experiment with certain feelings in a symbolic way. The patient may channel his aggression into a series of abstract works of interesting and powerful design which he may greatly enjoy making. This experience may ease his depression by providing an outlet for his feelings in a positive and constructive way.

It must be remembered that Art Therapy doesn't work in isolation; such paintings will be seen by the doctor in relation to the patient's general progress.

Many artists have used their work to channel feelings and ideas that expressed in any other form would be socially unacceptable. Art can be a cathartic experience not only for the artist but for those who look at his works. It cannot be for no reason that painters and writers to-day are so preoccupied with themes of violence and destruction. Art is sometimes the safety-valve of the people.

Art and Self-Realisation

In some kinds of mental illness, the patient may feel so unsure of his identity that he has to assume some kind of facade, a mask, a false self with which to protect himself from the world that he feels to be threatening. This is something which we may all do to an extent, but with most of us, the gap between the disguise and our true selves is easily bridged and we can distinguish between the two.

For the patient with schizophrenia, the false self may be the only part of himself that he dares to reveal because he is exceptionally vulnerable. He may withdraw so far from reality that he becomes, or feels that he has become, a hollow man. He may experience

himself as something outside life, like a shadow, or a ghost (see plate 4). A young man, formerly an Art Student, described how, when he tried to paint the view from the studio window, he couldn't really feel any contact with the paper, "The colour just goes on, but I don't really feel it, it doesn't seem to come from me." His attempted painting was pathetically fragmented. Later on I suggested an abstract painting which wouldn't include the strain of trying to translate the outside world. He produced some simple designs in two or three basic colours. The theme of each design was of one shape, contained within another. In this way he seemed to gain some relief from his anxiety, perhaps because in this way he had been able to achieve some kind of integration. Painting and modelling can be of importance in helping the patient with schizophrenia because it does offer him a way of relating himself to his feelings, and to his environment, and through these indirect (and therefore to him less threatening) ways to other people. No other form of communication can enable us to share his experience of being in the world, in such a vivid and moving way. In some cases, only through Art can we reach him, and can he reach himself.

A young married woman, formerly a university graduate, was admitted to hospital with what appeared to be at the time a severe depression. Her illness had started six months earlier after the birth of her second son. The first paintings showed little sign of depression, the feeling was rather of freedom and relief which she seemed to experience while painting. She talked mostly about her house, which she said was impossible to live in, because the neighbours were so noisy. It transpired that she had already moved several times for the same reason. From a painting she did later on, and by this time her style had considerably altered, it became clear that it wasn't the house she couldn't face, but the reality of living a normal life with her husband and children. This painting (plate No. 5) she described as herself and the ideal house. The painting has a rather nightmarish quality. She described the three heads in the right-hand corner of the tree-like structure as herself and her children. The small white rectangle on the left is the ideal house. There seems no reality in the painting, and no possibility of her reaching the house. She followed this painting with a series of self-portraits which became increasingly dehumanised (see plate 6), as her paranoid illness became more apparent.

Art, as I said at the beginning of this article, is no longer concerned with imitation, but with real experience. Paintings by patients not only enable us to experience what it can be like to be mentally ill; the activity itself provides the patient with a means of communication, self-expression, and self-realisation.

Painting also emphasizes the individuality of the patient and provides us with a constant reminder that a diagnosis does not describe a man.

DAVID HERBERT IRISH, M.B., B.S., D.A.

Many Guy's men and women will be shocked and sad to know that David Irish has died. As student and houseman, and later in Bedfordshire, he was both loved and admired. He was full of the joy of living and this he passed on to others. Not only was he one of those men who have no enemies, but those who knew David would find it inconceivable that anyone, anywhere, could say of him one word of disparagement. An engaging levity was combined with an impressive dignity and gaiety with a serious understanding of life. It never appeared that his stammer ever handicapped or worried him, therefore it never worried anyone who knew him, and somehow it enriched his personality. He had a very pretty wit and that was always worth waiting for.

As a student, he played hockey and fenced with distinction, and in all his activities he was a contributor. There was at that time a small chamber group which played very assorted music, quickly and deftly arranged by one of their number, for whatever instruments were available, and to this also David added his contribution, on a trombone. He did the full run of house appointments, ending as H.P. and Vice-President of the Residents. It was during this time that an occasion arose when he was persuaded to descend to the basement of the College by the small lift in which the coal buckets were hoisted to the upper floors. He arrived safely to the kitchen to the surprise of Sophie—also of blessed memory—and the other maids, who were taking tea. David returned breathless to the upper floor to describe the enjoyment of his journey and the surprised reception of his arrival, and when asked how he had dealt with this, he said, with even more than his customary stammer, " I got out, dusted the coal from my clothes, mustered up my customary dignity, and passed it off with a merry-quip."

He joined an old practitioner in Shefford and subsequently carried the full burden of a practice, which had expanded with him, single-handed through the length and heaviness of the war years. During this time he gave anaesthetics at Bedford and Hitchin Hospitals. Some relief came after the war, when his brother joined him, and later a third partner, but the demand for his particular wisdom, warmth and strength, never lessened. He obtained his D.A. and continued his sessions as an anaesthetist, which were a change from his practice and a great joy to him, and an equal joy to his hospital colleagues.

When he began to suffer from angina he carried on unresenting and unruffled, doing as much as he was advised, but still doing everyone else good with his usual gaiety and zest for his work. After a severe attack made it clear that he could no longer continue all his activities, he had made plans to combine some professional work with a well-earned semi-retirement. All was ready for this future enjoyment; he had apparently weathered the storm, was feeling well again, and then in a few seconds he died. He had made his family life as full, warm, and rich as his professional life. His wife, Paddy, enjoyed the same affection and respect at Guy's and in Bedfordshire, and one cannot think of them apart. The loss to her and their devoted family can only be fully appreciated by the many who will remember David Irish.

C.G.B.

NURSING NEWS

Throughout the history of nursing at Guy's there have been various excursions into the pages of the *Gazette*. Most of the columns in the past have been entitled Nursing News and have followed the title literally in a narrow way. There have been few articles by nurses and no editorials.

Due to the combined efforts of a number of people, it is hoped that a regular nursing section will appear with editorials and articles. Senior staff changes and reports on nursing events will be published. We hope there will also be comments and criticisms on the views expressed, in the correspondence columns.

This entry into public expression will, it is hoped, bring about further emancipation of the nurses within the various professions who go towards the making of the medico-scientific Guy's hospital.

Due originally to the efforts of Miss Nightingale and Mrs. Bedford Fenwick (founders of the Royal British Nurses' Association and the National Council of Nurses), nursing was recognised as a profession and the nurses' status eventually became very high. However, nurses have continually been set on ethical pedestals and are still spoken of as hallowed beings following a vocation.

It has only been during the last decade that this country has recognised that although the work done by nurses is of paramount importance, yet they are now playing a smaller part in the welfare of the patient.

A nurse needs to combine and co-operate with all the departments necessary for the well-being of the patient, and yet not lose sight of the fact that she is still responsible for the small and large personal tasks that are of the greatest importance both to the patient and his treatment.

It is very satisfying to hear thanks from the patients, but these are usually directed towards the nurse or the immediate doctors concerned. There is so much more done to-day for the patient by those who work out of the limelight which is also vital, and the patient must be encouraged to recognize this.

Having educated the patient into the conception of a united front of workers for his well-being, one must turn again to educating nurses and students alike to look upon their various occupations as integral links which combine to form the hospital health service.

The liaison between nurses and students outside working hours and the co-ordination of their activities, will serve to contribute towards a united health service from the outset of their appearance in professional life.

At times the student population of Guy's has attempted the introduction of communal activities, but it is due to the lack of nursing support (mainly through inconvenience of duty times) that these attempts have fallen on stony ground. With the help of the shorter working week, it is to be hoped that nurses will begin thinking of their profession as integrated with and not divorced from general medicine.

STAFF CHANGES AND APPOINTMENTS

Sister C. Fletcher, trained Boston General Hospital, to Sister in charge of Stephen Ward.

Sister E. Montgomery, trained Royal Free Hospital, to Christopher Ward, 16.5.66.

Sister C. Milligan, trained The Royal Victoria Institute, Newcastle, as Sister on Theatres.

C/N M. Williams (née Girdlestone), Guy's trainee, to the School of Nursing.

C/N H. Radford, Guy's trainee, as Acting Sister on John Ward.

S/N Pritchard (née Tapper), Guy's trainee, to Nuffield Theatres.

S/N D. Hall (née Brunning) Guy's trainee, to Nurses' Sick Room.

S/M C. A. Carbery, trained Royal South Hants. Hospital, to Victoria Ward.

S/N B. Houghton, trained Hammersmith Hospital to York Clinic.

S/N A. McKnight, trained Royal Free Hospital, to Martha Ward.

S/N J. Homan, trained Addington Hospital, Durban, S.A., to Samaritan Ward.

S/N V. C. Allford, trained Royal Infirmary, Dundee, to Nuffield, C. Floor.

SPORT

After the previous week's complete washout due to the weather, the summer season got off to a splendid start in glorious sunshine. The cricket club's two sides both played twice, resulting in a win and a defeat for the 1st XI, and two easy victories for the 2nd XI. The 1st XI lost to Lloyd's Bank, thanks to a fine innings of 133 by one of the opposition's opening batsmen, but the next day Guy's beat the London Hospital. C. Pearson, a fresher at Guy's, made a fine start to his hospital cricket career by scoring two half-centuries, the second in only half-an-hour.

The 2nd XI beat Lloyd's Bank 2nd XI quite easily, thanks to a determined innings of 83 not out by Martin Jones. The following day, Guy's beat Wates by 7 wickets.

Unfortunately by the next Wednesday, the weather had reverted to its previous unreliability, when the 1st XI's fixture against The Wanderers was abandoned without a ball being bowled.

However, it is in athletics that Guy's sportsmen have excelled during the last fortnight. Guy's athletes put up a magnificent performance to retain the University of London Championships at Motspur Park. The winning margin was increased on last year, and from the results below it can be seen that the reason for success was a determined all-round effort by all concerned, and not due to one or two star performers. Obviously this result augurs well for the U.H. championships in June.

A few months ago notice was made in the *Gazette* of the cricket bat recovered in the rebuilding of the Nurses' Home. This bat was made as a trophy in 1939 for a cricket match between the Cricket Club and the Nursing Staff. It is hoped to reintroduce this cricket match later in the summer, and Matron has kindly agreed to having the game as an annual event, assuming sufficient interest can be aroused among the Nursing Staff.

Over the last few years the M.C.C. have introduced their single wicket competition at the end of the season. A single wicket competition is cricket's equivalent to Rugby's Sevens and, due to the increasing popularity of such an event, the Guy's Cricket Club hope to have their own competition as a fitting climax to their season.

The London to Brighton stroll took place on May 6th and 7th in rather wet weather. Results will appear in the next issue.

DIARY

CRICKET

MAY

Sat. 14th—Strollers, 2.30 p.m. Home.
Sun. 15th—Reigate Pilgrims, 11.30 a.m. Away.
Sat. 21st } Birmingham Medical Students, 12 noon. Home.
Sun. 22nd }
Tues. 24th—Incogniti, 11.30 a.m. Home.

CRICKET

Prospects 1966

With the passing of only three of last year's 1st XI and the subsequent influx of a considerable array of talent, the problems of team selection this year are going to be ones of omission. An adequate replacement has yet to be found for Knott in the role of opening bowler, but with this reservation alone the side would appear to be very well balanced. If form measures up to potential and the standard of fielding improves beyond that of recent seasons, then this year should be both enjoyable and successful.

Predictions of the outcome of the Cup Competition are hazardous and unprofitable. Guy's have been drawn in the more difficult half which is, perhaps, a good thing if they are going to reach the final. The fixture list, of which the Cup is only a small part, continues to contain many of the leading London clubs where the reputation of Guy's cricket is made or lost. An innovation this year is a two-day match against Birmingham Medical School later in the month.

The 2nd XI, under the captaincy of Brian Rowlands, promises to equal the successes of last season. Their fixture list is not as full as it might be and additions hope to be made, as does the introduction of a regular Saturday 3rd XI.

JOHN POWELL-JACKSON
(Captain).

GUY'S v. LLOYDS BANK

At Beckenham. April 30th.
Result: Lost by 81 runs.

Scores:

Lloyds Bank, 222 for 4 declared.
Guy's, 141 all out. (Powell-Jackson, 60; Pearson, 54.)

On a beautiful day, and in perfect surround-

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ings, Guy's started their season by losing the toss and then the match. It was not, however, as clear-cut a result as the scores may suggest.

Lloyds batted first, and it was soon apparent which side had patronised the Crystal Palace indoor nets during the winter and which side required an unlimited supply of fielding practice. Guy's shortcomings in the field, which is quite natural for this stage of the season, in no way detracts from the fine innings of 133 by their opener, D. G. Landy. He was well supported by the middle order batsmen, and this, with a fast outfield, contributed to a comfortable declaration, leaving Guy's to score 220 runs in much the same time. A scoring rate of over 90 runs per hour was required.

Guy's answer to the challenge was, unfortunately late in coming and by then merely a token gesture. The first five batsmen suffering from the heat or the large tea were dismissed for 19 runs. Powell-Jackson and Pearson were then involved in a sixth-wicket stand of 96, lasting just over an hour. The main features of this were Pearson's ability to curb his natural fine attacking game to each alternate over, and then the unfortunate lack of communication between the batsmen which promises to be corrected in the future.

When they had gone there remained only 15 minutes to play and 2 wickets to fall. Successive balls from the Lloyds opening bowler put paid to any dreams of a draw.

J. POWELL-JACKSON.

GUY'S v. THE LONDON HOSPITAL

At H.O.P. May 1st.

Result: Won by 54 runs.

Scores:

Guy's, 162 for 8 dec. (Pearson 55 n.o.; Silk, 34; Swift, 25.)

The London, 108 (Beacham, 4 for 24).

Guy's batted first on the second day of a glorious week-end. It was very pleasant to see so many people watching the cricket, as it gives a tremendous stimulus to the team's performance. The players do appreciate the efforts made by their supporters.

Guy's start was better than the previous day, but it was not until Swift had joined Silk that the scoring rate became respectable. A good stand of 60 was rounded off in flamboyant style by Pearson, who scored his fifty in half an hour. Guy's were thus able to declare and set their opponents the target of 160 runs in 135 minutes.

After the tea interval, Beacham's first ball removed his opponent's middle stump. This one act had the great effect of elevating the above bowler's tail to a height not seen for many a long day. He continued with 10 overs of accurate pace bowling, managed to move the ball both ways off the seam and continually caused the batsmen concern. The spinners completed the work begun, helped by the impressive wicket-keeping of Swift.

J. POWELL-JACKSON.

ATHLETICS

UNIVERSITY OF LONDON CHAMPIONSHIP

Friday, 29th, and Saturday, 30th April at Motspur Park.

1st—Guy's, 72 points.
2nd—London School of Economics, 52 points.
3rd—Imperial College, 47 points.

In this meeting the hospital retained the championship which it won last year. The margin of victory was, however greatly increased and the large number of points obtained enabled the hospital to win the aggregate cup awarded for the greatest number of points relative to the number of people in the college. Guy's has not won this trophy for 31 years.

Victory was due mainly to the versatility of our field event athletes. A glance at the results shows that Guy's had two people in the first six in nearly every field event.

In the heats on Friday, Tong and Cheeseborough were unfortunate in having particularly fast heats in the 100 yards and failed to qualify. However, Bates and Domaingue scored an early success in the triple jump by obtaining first and second places respectively, the margin of victory being fractional in this case.

D. Choat ran well in his 880 yard heat and qualified for the final. His time was a good one considering the early stage of the season and augurs well for the future.

D. Osborne gained further valuable points by attaining second place in the discus.

In the 440 yards T. Higginbottom ran well to qualify and Domaingue and Bates rounded off a successful evening by qualifying for the 120 yards hurdles. At this stage Guy's had a slender lead over Imperial College—a state of affairs which was soon remedied in the first event on Saturday afternoon when G. Edwards procured an excellent throw to gain second place in the Hammer. B. Hartley—a comparative novice in this event—was recruited at the last moment and with characteristic nonchalance achieved a notable third.

A. Ross, another fresher, although putting well below his best, gained second place in the shot with Osborne adding to the tally.

Owing to a dearth of long-distance athletes, the hospital's lead was considerably diminished at this stage whilst King's, L.S.E. and Imperial College gained points in the mile, three miles and the steeplechase.

However, Edwards and Bundred, with a complete lack of practice, gained second and fourth places in the pole vault. The versatility of both Bates and Domaingue enabled Guy's to gain two placings in both the long jump and the hurdles. Our lead at this stage was twelve points—a figure which was increased with every subsequent result.

D. Barford was narrowly beaten into 2nd place in the 220 yards and W. Annan again proved his reliability by gaining third place in the high jump.

Hartley and Edwards provided an entertaining duel in the javelin, the former's 181ft. "no throw" costing him second place. This event was won with a record throw of 210 feet.

In the final event, Higginbottom ran strongly to finish fourth in the final of the 440 yards, leaving Guy's with a very wide margin of victory.

Only three "firsts" were gained in the championships and so one must look to the fact that Guy's were able to enter a number of extremely keen athletes—most of whom obtained points. This fact is probably the finest illustration of the value of participation and enabled the hospital to defeat the other colleges, most of which contain many more students than Guy's.

Results:

220 yds.: 2nd, D. Barford 23.2 secs; 5th, P. Bundred, 23.9 secs.
440 yds.: 4th, T. Higginbottom, 55.2 secs.
880 yds.: 6th. D. Choat.
120 yds. hurdles: 1st, J. Domaingue, 16.7 secs.; 5th, M. Bates.
Shot: 2nd. A. Ross, 43ft. 9in.; 6th, D. Osborne, 36ft. 8in.
Discus: 2nd, D. Osborne, 123ft. 2in.
Javelin: 2nd, G. Edwards; 3rd, B. Hartley.
High Jump: 3rd, W. Annan, 5ft. 9in.
Long Jump: 3rd, J. Domaingue; 6th, M. Bates.

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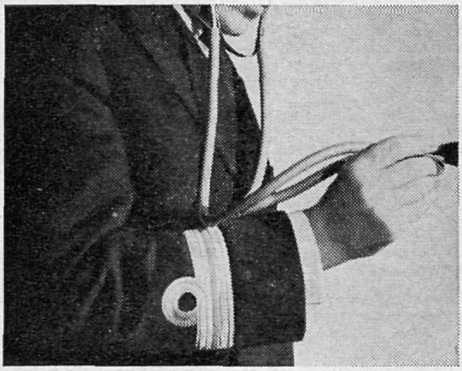

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3 Ways of Entry

1 As a fully registered doctor; any civilian experience counts towards your seniority.

2 During your pre-registration year.

3 As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

If you would like more information, write to the address below, giving details of your age and qualifications. A personal interview can be arranged if desired.

The Medical Director-General of the Navy, Dept. 26DN3, Empress State Building, London, S.W.6.

Royal Navy

Pole Vault: 2nd, G. Edwards; 4th, P. Bundred.
Triple Jump: 1st, M. Bates, 42ft. 4in.; 2nd, J. Domaingue, 42ft. 3in.
Hammer: 1st, G. Edwards, 116ft.; 3rd, B. Hartley, 65ft.

D. BARFORD.

GOLF

Registrar's "Open"
April 16th, 1966.

The Spring Registrar Golfing Ceremony (in honour of the late Mr. Barry Ross, and timed with characteristic precision to start simultaneously at Limpsfield and Crowborough Beacon on the stroke of 9.0 a.m.) got off to a splendid start at Piltdown Golf Club at noon.

Two minutes' silence on the first tee, in memory of our beloved founder, were broken only by errant borborygmi confirming what we had hitherto suspected: Dr. Rennie, at least, had the fire of battle, as well as Chateau Rauzan-Gassies '55, in his belly.

Mr. Carruth, nasal speculum laid aside, a gleam of defiance in his faintly blood-shot eyes, drove off.

Salome-like, the course revealed herself, stripping off her eighteen dank and sodden veils for our clinical enjoyment. Swans swanned about. Drizzle came and went. Even now and then derisive, unbalanced laughter or profane applause, echoed down the dripping fairways. Messrs. Wharton, Hywel Davies, Ross and Carruth were glimpsed, snaking to and fro across the sixteenth, like Wingate's Chindits smoking out the Japs.

The late Mr. Ross (Barry of the Bunkers as we had come to call him) had four mortar-like drives at the 260 yard 18th, the first three of which left him considerably more than 260 yards from the hole. We watched with ill-concealed admiration.

Nearer to earth, Mr. John Maynard played with application, fortitude and Dr. Ray Lascelles (whose back-swing is virtually pathognomonic of torsion dystonia). Dr. Lindsay's intense concentration was broken only by betting permutations before his every shot.

Afterwards, following the route Mr. Ross had carefully planned to by-pass Brighton and so reach "Thatchings", Mr. Ross got most of the party lost in the middle of his home town (Brighton). Dr. Lascelles and Dr. Rennie, travelling in Dr. Rennie's privately entered 1957 Ford Anglia were, despite the tuning, unable to keep up. So, three hours later, at Bognor Regis Police Station, they were granted the privilege of hearing the Station Sergeant saying he was a stranger there himself.

April 17th, 1966.

Up at crack of 7.0 a.m. and to mountainous Goodwood, home of the brave and of Dr. Max Lindsay who, pausing only to raise the stakes, drove off against Dr. Hywel Davies. Dr. Lascelles followed, stringing birdie to bogey in the most boring and repetitive fashion, whilst annihilating Dr. Rennie who, weakened by playing some 60 holes the previous day, went round on hand and knees. Behind them golf balls bounced exuberantly amongst the elms as Messrs. Ross and Maynard spread themselves generously about the course.

As they played the 17th, Dr. Wharton and Mr. Carruth played the first in somnambulist style, Dr. Wharton, in fine form and Hush-Puppies.

Over a prolonged luncheon, disintegration set in. Dr. Lindsay paid a large sum of money to Dr. Hywel Davies (sportsman; bon viveur) and began to enlarge on his own psychological difficulties. Your correspondent left when it was clear that Dr. Davies was about to insist that Lloyd George had indeed known his father.

Piecing together the events of the afternoon is impossible due to a complete collective amnesia lasting until the long fourteenth. Much later, the mortal remains of our founder were conveyed to their resting place, Trinity Square.

I.D.B.R.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

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HOUSE SURGEON, vacant 10th June. Six months' appointment. National salary and conditions.—Write with testimonials, references, to Group Secretary, G. and D., H.M.C., Greenwich District Hospital, St. Alfege's Wing, Vanbrugh Hill, S.E.10.

PASS LIST

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Diploma
Vernon H. Bartley

PAPERS BY GUY'S MEN

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PERSONAL

WANTED, evening work, typing, secretarial, reception etc., or would be prepared to undertake the typing of manuscripts, letters, etc., on a free-lance basis.—Reply to Box No. 7.

PRACTICE FOR DISPOSAL. No capital required. Retiring due to illness and age. —Further particulars ring L. Shaw at Paddington 0756.

FURNISHED FLAT for married couple to let for 4 months from July 27th.—Flat 3, 31, Trinity Church Square. Hop 4229.

BIRTHS

LIEBLING.—To Jean Liebling (née Sandison) and Peter, at home, on 14th April, a daughter, Penelope Jane, sister for Simon and Susan

DOBSON.—On 17th April, 1966, at Nuffield House, to Kate and Bill Dobson, L.D.S., a son (William Shelton), a brother for Nicholas and Guy.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

DEATH

COOKSEY.—William Octavius, L.D.S., R.C.S., on April 30th, at Liverpool Terrace, Worthing.

EDITORS A. E. RAYNES and M. F. D'SOUZA

SPORTS CORRESPONDENT G. E. RATCLIFFE

NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2030

PASSIM

Passim on Passim

"It's all been said and it'll be said again; true or false. A comforting thought. . . ."

Depending upon our pet foible, fixation or fanaticism, this age of ours will be named in many different ways. Scientists will summon statistics, artists invoke styles, politicians orate "isms", physicians follow fashions and socialites ooze eponyms. But common to and above all, it will be the Age of Criticism.

The contributory factor is having its heyday, and infinity is overpowering finality. Never before has so much been said by so many who know so little. But let us be grateful that they do say it, for while each opinion may be tangential it adds its contribution to the formation of the circle—the neat rounding-up of the matter and a stepping-stone to a more elaborate future. The critic reveals what the creator conceals, hoping to improve the future creation. He serves as a reminder as he lifts the carpet and blows out what has been brushed underneath. He speaks often and loud. He despairs on one hand as nobody appears to act on his criticism, and rejoices on the other for by this his livelihood is assured. When he forgets his total egoism he recognises that things progress in spite of him yet his self-respect demands that he occasionally feels that some of the progress is because of his words. His nightmare is that he has been relegated to the status of the week-end colour supplements. His name is *Passim* [L.=scatteredly]. So here is our fortnightly Muggeridge/Levin. The former recently complained of his television programmes that he was seen and not heard. We are seen in this column, admittedly not as glamorous as the cathode ray, twenty-six times a year. Are we heard?

James Saunders.

Rag Redress

In our correspondence columns this week we print a letter concerning a dance which is planned to be held on June 8th on board the riverboat "Royal Daffodil". The purpose of this venture is to raise enough money to offset the quite considerable debts incurred by the damage at the recent cup final Rag. This would seem an enterprising and enjoyable way of acquitting the Hospital's responsibilities and it is to be hoped many people not directly involved in the Rag will consider buying tickets to ensure that all accounts are squared.

The *Gazette* has expressed its regret that the Rag should be the sole activity, apart from the Brighton Stroll, which commands student support and enthusiasm. In an age that is witnessing widespread human misery it seems somewhat degrading that intelligent and informed human beings can find nothing better to do with their energies than indulging in these unconstructive and often dangerous frivolities. It is not so much that they should not be but rather there should be many more worthy activities to justify their existence.

However, this present state of affairs could gain some indirect merit, for if skills are acquired in the difficult art of raising money, these could then perhaps be directed towards aiding a more worthwhile purpose.

It is with a great deal of regret that Guy's bids farewell to Mr. Stamm; the *Gazette* will be publishing a tribute to him in the next edition. We are sure that everyone in the hospital who has known him joins us in wishing him a most enjoyable retirement.

Mr. R. J. G. Day, who qualified B.D.S. in 1951, has been elected Mayor of St. Albans as from the 25th of this month.

Dr. L. Stimmler has been appointed Consultant Paediatrician to the hospital, and Mr. A. Henry has been appointed Consultant Orthopaedic Surgeon to the hospital.

Dr. W. J. W. Siddall has been appointed Consultant Anaesthetist to Torbay Hospital, Torquay.

Mr. I. McColl will deliver an Arris and Gale Lecture on "A Study of Intestinal Absorption in Surgical Patients", on Wednesday, 8th June, at 5 p.m. at the Royal College of Surgeons.

Mr. J. C. Gazet will deliver a Hunterian Lecture on "The Surgical Significance of the Ileocæcal Valve", on Thursday, 9th June, at 5 p.m. at the Royal College of Surgeons.

This week Passim bids farewell to Dr. Tony Raynes, the editor of the *Gazette* over the past year, who now moves on to pay the higher taxes incurred by the Review Body's award. In his stead we welcome Mr. D. S. Robins, a former editor of the British Medical Students' Journal.

GUY'S DIARY

MAY			
31st	Tu.	1.00	"Surgical Beauty—The Nose".
JUNE			
6th	M.	1.00	Mr. TOMKINSON. "Vital Statistics in Obstetrics".
7th	Tu.	1.00	Dr. JOINER.
10th	F.	1.00	Mr. BRAIN.

A Neurosurgical round will be held on Thursday, 16th June, at 5 p.m. in the Clinical Theatre, and will be conducted by Mr. Murray Falconer.

A Clinico-Pathological meeting will be held on Saturday, 25th June, at 10 a.m. in the Clinical Theatre.

GEORGE HADSHAR, L.D.S., R.C.S.

George Hadshar entered Guy's in 1957 at the age of 38 to commence the Dental Course. He had already served for 17 years in the Army with the Second Gurkha Rifles and the Buffs, and during that time he had been in active service in very many places, including Indo China. He went into the Army as a Staff College graduate and retired after he had held the rank of Major for several years.

Even those of us who went through the 1st M.B. and preclinical courses at the usual age will recall that these were difficult years; how much more so for someone starting so late in life. He certainly found it difficult, sometimes desperately so, but he was tough and he got through. There was not only the problem of assimilating the necessary facts, but also the adjustment to student life—to be told when he had been accustomed to telling.

He was always immaculately dressed, always punctual and good mannered, but lest anyone should picture a coldly efficient person from that description, he was a most considerate and warm personality. In recognition of this side of his character, he was awarded the Carlton Hunter Memorial prize, given to the student judged to have been the most considerate to his patients.

He qualified L.D.S. in 1964 and after nearly six years of effort he joined his wife in dental practice in Bletchley. Little more than a year elapsed before he became ill and after months of mental and physical pain he died. At an early stage he knew what was going to happen, and discussed it soberly, sometimes even in a jocular manner. He was well prepared for what happened, but his main concern was for the welfare of his wife and children, and indeed they must now be the concern of all his friends. All who knew George Hadshar will want to send their most sincere wishes of sympathy to his wife and family.

REG WOODMAN

Reg Woodman died in Guy's on Sunday last. He loved the Hospital and it would be hard to find anyone who had so many friends amongst the past and present staff, both medical and nursing. So many of us will remember the bald head, friendly smile, the handle-bar mustachios, the trolley piled with cartons—in fact, Reg doing a delivery from his off licence in St. Thomas' Street. Nearly a year ago he was found to have a malignant condition and because of his business commitments and his interest in medical matters, he had to be told most of the truth. Reg was in and out of hospital, but as far as it was humanly possible, he carried on with his business as if everything was normal. The same old smile, the same "stop me if you've heard this one", while knowing that he could not last much longer.

Those of us who knew him will never forget the incredible courage that enabled him to remain cheerful to the last.

G.W.S.
T.H.H.

RE-INTRODUCING

JOHN DICKSON

FIRST PSYCHIATRIST AT GUY'S

by

J. J. Fleminger

John Thompson Dickson was last mentioned in this *Gazette* in 1874. Now, after nearly a century of eclipse, his name is amongst us again. The fourth floor ward of the York Clinic has been named John Dickson ward.

Dickson was born at Brixton Hill on 4th March, 1841. His father, William, was partner in a firm of merchants in Bishopsgate. Before marriage his mother had been Miss Madeline Hendrica Vos.

His early education was private. In June 1860 he entered Guy's as a student at the age of 19. The Medical School records show that his skill at dissection received high praise and that he became clinical clerk to Dr. G. H. Barlow. He obtained the M.R.C.S. in 1863, and in the same year he entered Gonville and Caius College, Cambridge, as a scholar. His career at Cambridge must have been unusual. After two terms at Caius he migrated to Downing College. Two years later, in December 1865, he was admitted to St. John's, not an ordinary undergraduate, but as a Fellow Commoner, which entitled him to dine at the Fellows' table. In the next year he was placed in the First Class in the Natural Science Tripos, and by 1869 had acquired the M.A. and M.B. of Cambridge and the M.R.C.P. (London). In 1866, however, he had already become qualified to practise medicine by obtaining the Licentiateship of the Society of Apothecaries. But there was another event in that year which was to have important consequences both for Dickson and for Guy's: the University of London had recommended that special instruction in Psychological Medicine should be given at all medical schools. The first course of lectures and demonstrations in Mental Diseases at this hospital was given by Dickson in the Summer term of 1869. He was formally appointed Lecturer in 1871.

Before his appointment at Guy's, Dickson had gained his psychiatric experience first as Assistant Medical Officer at the City of London Lunatic Asylum (now Stone House Hospital, Dartford); then as Medical Superintendent of St. Luke's Hospital.

He had also held an appointment at the Margaret Street Infirmary for Consumptives, and was Physician to the Infirmary for Epilepsy and Paralysis (later the Hospital for Diseases of the Nervous System). Finally, not least, and perhaps appropriately for a man of such remarkable career, he was Honorary Physician to the Royal Dramatic College.

From what we know of this enterprising man, it is no surprise to learn that he joined many medical and learned societies. He was a

Fellow of the Linnean Society and the Medical Society of London; he was a member of the Pathological and Dialectical Societies and of the Medico-Psychological Association. He is said to have taken part in discussions with "spirit and effect"; but, as we shall see, it may have been with too much spirit and with too little effect.

Dickson had given hint at Cambridge that he was a mobile man. This is confirmed by his changes of address which took him from Clapham Park South to Bryanston Square via Kings Bench Walk and the streets of Wimpole, Harley and Queen Anne, in the six crowded years 1867-73. But if he was a rolling stone it could not be said that he gathered no moss. His publications bear ample witness to that (2—19).

Dickson had several special interests in the field of neurology and psychiatry, but first among these was Epilepsy. Nine of his published papers were devoted to this condition, and to the mental disorders associated with it. He had the temerity to dispute Hughlings Jackson's view that the behaviour of muscles in an epileptic convulsion is due to a "discharging lesion" in the brain. He preferred to think of the brain as giving up control over the musculature, thereby releasing "reflex excitation". General Paresis was another topic to which he gave much attention. ". . . the form of mental disease that most commonly has its origin in syphilis is probably dementia or paralytic dementia". He reported some careful clinical studies and speculated on the connection between the predominantly paralytic cases seen in the wards of Guy's and described by Wilks (21), and the predominantly psychotic patients to be found in the asylums.

There was a strong speculative streak in Dickson and he presented several dissertations on supposed associations between cerebral and mental and bodily events. But this inclination to think aloud and ahead of the facts seems to have been counterbalanced by an equally strong practical bent. A contemporary wrote that "he was no mere speculator, but a skilful operator in physiological experiments". His early skill at dissection led to his personal preparation of pathological specimens for both study and teaching throughout his professional life. Moreover, he possessed one important attribute of the original mind: a determination to rely more upon his own observation than upon any body of received dogma or current opinion. Nowhere is this better shown than in the paper that he read to the Medical Society of London in 1870 and which was later published in the Journal of Mental Science under the title "A Contribution to the study of the so-called Puerperal Insanity". In this he dismissed the contemporary use of the term Puerperal Mania and claimed, correctly, that the melancholic form was as, if not more, frequent. In fact, he rejected the concept of Puerperal Insanity altogether: "There is nothing peculiar in the insanity of child-bed . . . puerperal insanity is ordinary insanity appearing at, and only slightly modified by the childbearing circumstance." He disapproved of the use of "puerperal" as applied to insanity in an "adjectival sense". Today these views may sound commonplace but the independence of mind that gave voice to them may be appreciated when we recall that he had been qualified to practise for only four years, that the most authoritative

textbook at that time, the excellent Psychological Medicine by Bucknill and Tuke (1), presented the contrary viewpoint, and that the concept of puerperal insanity of predominantly manic type was upheld almost unquestioningly in the text book by Sir George Savage (20), who was Dickson's successor at Guy's.

Dickson's lack of professional piety was accompanied by a strong critical sense and social conscience. These qualities combined to produce his most widely known public statement. It is ironic that this appeared anonymously. It was the leading article in the British Medical Journal of October 1870, entitled "A Social Blot", and it referred to a recent report by the Commissioners in Lunacy. The notoriety of this article was due to its harsh comments on the maltreatment of insane patients and its criticism of the management of asylums.

The attendants were overworked and underpaid; "half Herculean, half brute, almost uneducated and without qualities or feelings above the animal appetites". Among many types of violent injury suffered by patients, broken ribs were reported from several asylums: "We have no intention of entering here on the question whether lunatics' ribs are more brittle than those of other people. If they are, lunatics require all the more careful handling. . . . But rib-crushing, although the favourite, seems not to be the only mode in which lunatics are hurried out of existence." Then other familiar brutalities are mentioned, and he asks why they occur and suggests his remedies. First there was the laxity of the Law. The Commissioners should be far more numerous and given greater powers. Also he believed that better pay would recruit better attendants. But the animus that this article aroused, and Dickson's unpopularity when his authorship became known, must surely have been due to his remarks about the Medical Superintendents of Asylums. He observed that they were often inefficient, that their work was badly paid, unpopular and arduous and, as a result was regarded as "a refuge for the destitute". Moreover, they were "not recruited from the first ranks of the profession". Finally, he flung a charge at the private asylums. They were failing to provide adequate care and amenities because of their "study of parsimony". All this, one should note, was written by a man who had but recently left his post of Medical Superintendent at St. Luke's Hospital. No wonder that he was said to have "greatly stirred the passions of his brethren", and no wonder that "A Social Blot" was said to have "excited a good deal of just indignation in those members of the B.M.A. who were slandered by it". It is doubtful if he lived long enough to live it down; yet with the hindsight that history has given us, how justified we now know him to have been. "A Social Blot" may have been brash but it was neither false nor untimely. It was a challenge and a call to vigilance at a time of complacency. Let us hope that we are no longer so complacent about the care and treatment of the mentally ill, that we should resent or rail against the just claims of a critic, even if he does appear to us to be an upstart crow.

Dickson's formal teaching at Guy's consisted of a three months course in the Summer term. There were two parts to this: twelve

lectures, illustrated by photographs and pathological specimens, were given at the hospital on Monday mornings at 10 o'clock; and twelve case demonstrations were given in the wards of Peckham House Asylum on Friday afternoons. In each lecture he referred to cases shown at Peckham the previous week. At that time there was little opportunity to use Guy's patients for teaching mental diseases. The admission of lunatics, which Guy had requested, had long since been stopped, and the original house which had provided room for twenty such patients, and which stood where Shepherd's House now stands, had been converted to other clinical use ten years before. When George Savage took over from Dickson, the visits to Peckham ceased and students went instead to Bethlem Royal Hospital in Lambeth, which is now the Imperial War Museum.

The lectures were published as a book in 1874, and were dedicated to Philip Casenove, a governor of both Guy's and St. Luke's Hospitals. In keeping with the habit of the day it had a long, descriptive title: "The Science and Practice of Medicine in Relation to Mind, the Pathology of Nerve Centres and the Jurisprudence of Insanity, being a Course of Lectures delivered at Guy's Hospital". He wrote in a superbly vigorous style and vivid clinical anecdotes enlivened the text. After a general introduction he devoted his second lecture to the legal aspects of the subject, which were even more thorny then than they are now. Lectures 3 to 5 were concerned with conditions that were then called varieties of "Mania". Acute cases seem to have been excitements of all kinds, including those due to schizophrenic and symptomatic psychoses and those that we still call mania or hypomania. His chronic cases would today be classed mostly as schizophrenic although they must have included some cholia, for which microscopic evidence of a cause in the brain was being eagerly sought at that time; and lecture 8 was on General Paralysis. In lecture 9 he discussed "Dementia". There were three types: first, acute dementia, which was probably nearly always a stupor of some kind. Then chronic dementia, which followed an acute illness and was what we now call chronic schizophrenia. Finally, "Primary" dementia, which comprised those "organic" reactions or encephalopathies for which we still use the same term. In lecture 10 on Idiocy and Imbecility he emphasised the importance of community life and education for the sub-normal. His last two lectures were devoted to Treatment, Classification and Aetiology, giving surprisingly great attention to the probable role of the emotions in the causation of mental illness.

Let us cast a few brief glances at the psychiatric scene as it was presented to students at Guy's nearly a hundred years ago:—

"It was felt that the relations of Insanity to Medicine had become so important that a course of the study of the latter was incomplete if it excluded the former, and therefore this supplementary course was instituted.

"The synonyms Psychiatry and Psychological Medicine which of late have, unfortunately, been imported into our scientific nomen-

clature, are in themselves almost delusive, pointing as they do to the psyche or soul, of which it is not our province to treat.

"If we used words with more precision we should have fewer difficulties in studying medicine.

"The subject of our enquiry is the mind in a condition of disease . . . we shall find ourselves lost in a boundless and unfathomable ocean of speculation if we go beyond the brain for explanations of the phenomena of thought and madness . . . we shall regard all mental phenomena as the result of changes in the cells of the brain or the resultant of forces acting on or bearing upon the brain cells.

"Diseases of mind are not different per se from diseases generally.

"The actual cause of insanity in all cases is undoubtedly malnutrition of the brain, but aetiology seeks to know something more and looks for a cause for this malnutrition.

"The wear and tear of daily life in these high-pressure times seems to produce changes in the lining of arteries of the brain.

". . . in the present day whilst we are living at railroad speed and whilst everyone is making haste to get rich, whilst competition runs high, whilst want and privation are the necessary lot of thousands . . . it is not to be wondered at that some of these should wander and depart from a normal and healthy mode of mind and thought.

"The effects of railway travelling in the predisposed should be thrown into the scales on the side of exciting causes . . . it appears highly probable that the motion . . . tends to exhaust the brain by the vibrations conveyed to it through the spinal cord.

"The desire for fulfilling the act of reproduction is strongly implanted in women, and the non-satisfaction of it is reflected back upon their nervous system.

"There are, in fact, a large class of disorders in which the emotions are disturbed, which border very closely upon and sometimes run into insanity, and which, I believe, are associated with abnormal conditions of the Sympathetic.

"The popular notion that the will is primarily at fault in the neurosis called 'hysteria' is incorrect. The patient's will is overwhelmed by the excess of emotion and the notion that such patients have 'only to make the effort' is as ridiculous as the name which refers the disorder to the uterus.

"Alas! we may almost be tempted to regret that we have such a word as hysteria, so often has it been used as a cloak for ignorance.

"The conflicts that arise in court between doctors and lawyers on the subject of insanity are too often exceedingly painful and a slur upon common sense and the enlightenment of the age.

"I am inclined to believe that bye and bye physiognomy will become of great use to us in the diagnoses of many diseases, and perhaps in particular in those which we term mental.

"So strongly have I felt upon the subject of opium . . . that I never once prescribed the drug in any form during the whole time that I had charge of St. Luke's Hospital . . . my practice was always to order wine or brandy with beef-tea or eggs for a restless case . . . of all medicines, however, chloral is perhaps the one most to be relied on.

"The statistics of St. Luke's Hospital . . . show that the percentage of recovery in that institution has often been not far short of 70.

"There are on record cases of insanity which have recovered after 20 years of seclusion, and considering this fact, we rarely need speak hopelessly of any cases we have to express an opinion upon.

"The study of mind has too long been trammelled with metaphysical considerations to allow of clear exposition of its various phenomena, but the shackles are now unloosed, and we may return from metaphysical dreams to a solid and material basis.

". . . the end and aim of our study is the amelioration of suffering and the lessening of that burden which each one has to carry as his allotment of human ills."

Today it may seem to us that some of these observations were foolish and that some were remarkably wise. Most, of course, were neither; although some sound strangely up to date. However, only a fuller reading of Dickson can convey his strongest quality; his sense of confidence and pride in his chosen branch of medicine. For him, to misquote Pope: the proper study of mankind was mind.

The reviewer of his book in The Journal of Mental Science commended its freshness and originality but deplored Dickson's "serene self-confidence . . . he not seldom pronounced with authority where diffidence or doubt would have been more becoming". To illustrate his point he quoted some of Dickson's remarks on the subject of masturbation. "Mania associated with masturbation is by some considered a variety, but I am not inclined to consider it in this light . . . it is practised by the young of both sexes to an incredible extent . . . and after a time both boys and girls who have practised it at school give it up." The reviewer disapproved and wrote: "Would it were certainly so!" But by this time Dickson was unable to reply because earlier that year he had suddenly died.

He had suffered a severe attack of rheumatic fever when he was 15 and it had been known for several years that he had serious mitral disease. For some time before his death he could hardly walk twenty yards without stopping for breath. He had been fully aware of the nature of his illness for a long time and he was often acutely distressed by it. Yet in spite of this, "he thought, wrote and did as much as if he was hale and robust". Moreover, he was interested in the effects of rheumatic heart disease on the mental state, and wrote, "I am inclined to believe that a mild form of melancholia almost always follows acute rheumatism or accompanies early heart disease. In both cases you can almost always see great depression of spirits and this may readily overstep the boundary line of sanity. . . . In my experience, mitral imperfection sets up a transient melancholia, but aortic disease produces a more permanent form of disorder."

On 5th January, 1874, Dickson was sitting and reading in his carriage on the way to visit a patient at Sydenham. His wife was with him and as they were going along the Vauxhall Bridge Road she saw him lean forward suddenly as if to open a window. When she spoke he failed to reply and was found to be dead on their arrival at a doctor's house nearby. Two months later he would have been 33 years old.

An obituary in the "Medical Times and Gazette" spoke of his unfailing courage and energy and suggested that his outstanding professional characteristic was "earnestness of purpose in physiological enquiry . . . never doubting that good would come of it". At the time of his death he had just finished correcting the proofs of his book and had been working hard at private and hospital practice as well as on "nerve preparations". By contrast to the reviewer of his book, his obituarist wrote: ". . . though his knowledge was most extensive and varied, he entertained a very modest opinion of his own acquirements".

But at Guy's, "where he had created for himself a name as a devoted and successful teacher", who sang for Lycidas, "dead ere his prime"? We cannot say, but we know that the best that this Gazette could muster was a bare quotation from a notice in the B.M.J.; and we find no mention of Dickson in the histories of the hospital. Now this has been remedied, and, late but at last, we can pay our tribute.

John Dickson did not leave us an illustrious name but we may still be guided by him. Guy's first psychiatrist was a luminous and memorable man.

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NOTICES

Sports Day

Sports Day will be held on Saturday, 11th June, at Honor Oak Park, commencing at 2.30 p.m. There will be a varied programme of events and amusements, and a dance and barbecue will take place in the Pavilion in the evening. Entry forms for the athletic events are available from the porter in the East Wing, and should be returned by June 3rd at the latest.

I should be very grateful if anyone who is willing to provide much needed assistance, both in running side-shows and in organising events, would contact me as soon as possible, by way of a note.

L. J. TURNER (Sports Day Sec. and Treas.)

Past and Present Cricket Match

This match is being played at H.O.P. on Saturday, June 18th, 11.30 a.m. start. Would past members wishing to play please contact Tim Huins at April Cottage, Badgeworth, Near Cheltenham, Gloucester, as soon as possible.

In the *Gazette* of May 14th, the name of the 2nd M.B. member elected to the Education Committee should have been M. Knight instead of Wright, and on the Nursing page it should have been C/N Wilkins (née Girdlestone), and not C/N Williams (née Girdlestone).

CORRESPONDENCE

Mr. George Doherty

SIR,—It is with deep sorrow that we here in Cape Town heard that George Doherty had passed away. I immediately contacted several Guy's men and arranged for suitable notices to be inserted in the press.

George was loved by all medical men in this country. He visited us frequently, and his holidays here with Sir John Conybeare were always looked forward to with joy by all of us and with dismay by our wives. It was one party after another, and our families and patients saw little of us. Our visits to the wine cellars at Paarl are still talked about by the executives of these farms. George would truly walk with Kings and commoners, and he was always the same old George.

Somehow he "took" to South Africans. I do not know whether it was a common love of rugger or not, but I do know that in the side he captained at Guy's there were 13 South Africans. They spoke Afrikaans on the field and according to Goldie van Skalkwyk, George knew all the swear words and understood the language more than he admitted to.

When World War II broke out, I remember George at Orpington with his two South African housemen, Steyther and Alkers. A great friendship grew up between them which lasted through the years. I was at Pembury Hospital at that time as houseman to Mr. Joey Hughes and the great Lambrinudi. Every time I visited Orpington it took me 48 hours to recover.

I only hope that when George arrived at the "pearly gates", a few South Africans were there to meet him wearing green Irish Rugger jerseys, bottles of Guinness in their hands and giving George the Zulu war cry.

We mourn a great Guy's man and a true sportsman in every way.

Yours, etc.,

L. BABROW.

13th May, 1966.
904, Norwich House.
Cape Town,
South Africa.

Nursing News

SIR,—As a past Nursing Correspondent to the *Gazette* for many years, I would like to send my best wishes for the success of the revival of "Nursing News". I note that the scope is to be widened. I am sure that both the news and the articles will give much pleasure to the large number of nurse subscribers.

Yours, etc.,

FLORENCE TAYLOR.

17th May, 1966.

Flat 2,
103, Blackheath Park,
London, S.E.3.

Royal Daffodil

SIR, As a result of the damage caused by the Rag at the Hospitals' Cup Final this year, a large debt has been incurred by the two hospitals concerned. In order to rectify this situation, a river boat trip has been organised for June 8th aboard m/v Royal Daffodil.

This large vessel, which will carry up to two thousand passengers, has been chartered for a five-hour trip down the Thames. Five bars will be open for the entire voyage, and a beat group will be performing throughout the evening.

We sincerely hope that all students, nurses, physiotherapists, radiographers, and anyone else who would care to enjoy themselves afloat will support this venture.

Many people will be selling tickets around the hospital, including myself and the Porter in the East Wing.

Yours, etc.,

J. O. SOUL,
(Secretary to the Organising Committee.)

17th May, 1966.

Students' Club,
East Wing, Guy's Hospital.

REVIEWS

THE AUTONOMIC NERVOUS SYSTEM,

By Harold Burn. Published by Blackwell at 18s. 6d. 2nd ed. pp. 134.

Those who are already familiar with the first edition of this useful little book will welcome the rapid appearance of a second. Professor Burn bases his book on lectures delivered over the past four years dealing with the autonomic nervous system from the standpoint of chemical transmission.

Whilst modern work is reviewed in great detail, the contributions of the earlier workers such as Langley are not forgotten. The complicated and intricate actions of drugs which block the sympathetic and parasympathetic systems are dealt with very clearly. There is experimental evidence to support each point that is made, and though the chemistry of the drugs is mentioned where this is necessary, it is simple enough to be comprehensible even to physiologists.

There are two new chapters on the role of calcium in the release of noradrenaline and on work with the electron microscope on the storage of noradrenaline and acetylcholine. These are interesting in view of Professor Burn's hypothesis of the release of noradrenaline by acetylcholine from the adrenergic nerve endings. Since the Burn and Rand hypothesis is not yet generally accepted, its inclusion in the closing chapters of the book provides a stimulus to thought.

Many pre-clinical students may feel that it is not worth buying this book, because of its extreme specialisation, but I would urge everybody to read it: if necessary pester your Public Library for a copy. For those who wish to pursue the subject further there is an excellent list of references.

LINDA F. GREENWOOD.

MEDICINE IN BRITAIN. A GUIDE FOR OVERSEAS DOCTORS.

By C. Allan Birch. Billiere, Tindall & Cassell, pp. 316. *Price* 35*s*.

In this preface the author states:

" The material is presented in short articles and statements which may be read independently of each other; those covering related subjects are loosely grouped together ". This is a fair description of this book, which contains a great deal of information about the National Health Service, the customs of British doctors, some clinical medicine, and a spot of history.

One third of the book is devoted to " The Structure of the National Health Service", but it is not always easy to locate information. Thus the health services of Eire have been included in this particular chapter and disciplinary action against General Practitioners comes in the middle of paragraphs devoted to hospitals.

The book contains sections on medicine, paediatrics, surgery, obstetrics and gynaecology. Here again the range is wide; in 31 pages devoted to "medicine", information is given about the difference between "Scotch" and "Scottish", the lunacy act, the side effects of steroids and a paragraph on early percutaneous carotid angiography in cases of subarachnoid haemorrhage.

It is difficult to know what has determined the content of this book; if it is meant for doctors from overseas working in junior hospital jobs (as it is suggested in the foreword by Lord Taylor), then there is much which is irrelevant. For instance, the financial information ranges from the salary of a consultant with an "A" plus merit award to the container allowance which is paid to a chemist on dispensing a prescription.

If the book is intended to be a source of comprehensive knowledge about the health service, then it is a pity that the information is occasionally inaccurate or out-of-date. Where this is not the case, however, there is quite a lot of interesting material in a reasonably digestible form.

J. A. D. ANDERSON.

REVIEW OF BASIC OTOLARYNGOLOGY,

By David A. Dolowitz.

The author designed this first edition for medical students and physicians, and has concentrated on the common conditions in a concise and authoritative manner. He has restricted the descriptions of operative techniques to the minimum.

Otosclerosis is described briefly, and it is a pity to read that the author still recommends the fenestration operation if Rosen stapes mobilization fails. There is hardly any mention of the operation of stapedectomy except in a schematic drawing. I disagree with the author in classifying Menière's disease as a third type of labyrinthitis.

The book contains useful chapters on infection of the upper air passages, disease of the oral cavity and salivary glands and tumours of the head and neck and their palliative treatment with chemotherapy.

To British teaching it has some obvious defects in the minor role ascribed to radiotherapy in the treatment of laryngeal and sinus cancer, the retention of the old classification into intrinsic and extrinsic in describing malignant tumours of the larynx and pharynx and the use of the Davis-Crowe mouth gag in tonsillo-adenoidectomy rather than the usual Boyle-Davis gag.

The chapters on headache are most up-to-date and worthwhile reading. The book ends with a very good chapter describing emergency treatment on the ears, nose and throat which the house officer might undertake.

The illustrations and presentation are of the usual high standard expected of American text-books. Bibliography at the end of every chapter is very good.

Although not to be recommended as a text for our undergraduates, it could well be a useful reference handbook for the general practitioner or students taking the higher examinations for the Diploma in Otolaryngology. However, it is quite an expensive book.

G. TOMA.

HANDBOOK OF HUMAN EMBRYOLOGY.

R. W. Haines, M.B., D.Sc. and A. Mohiuddin, M.B., Ph.D., 3rd Edition, E. & S. Livingstone Ltd.

The 223 pages of this small book contain 247 diagrams and drawings, many of them multiple. These are a testimonial to the ability of the authors to help the student see the 3-dimensional topography of the human embryo. They also serve to reassure the student revising the subject, that the actual wordage of the book can be read, if he be so minded, in a single day. This then is another welcome book which breaks with the mediaeval tradition in pre-clinical writing, that the value of a textbook is proportional to its weight.

Clear and succinct statements carry the reader easily over formation of the germ layers and much of organogenesis. Details so often drowned in the seas of large textbooks are not only mentioned, but become memorable, in a brief phrase. For examples one could point to the accounts given of yolk sac and amnion, prochordal plate and tailbud, pneumato-enteric recess, even oddities such as Froriep's ganglion. Descriptions of experiments are naturally introduced to illumine the text. Those on induction of the lens vesicle and spinal nerves, the fate of the neural crest and the development of limb buds are beautifully concise and readable. At the cost of a few minutes reflection they should give the interested reader a lasting insight into experimental embryology.

A considerable fault with the book is the fragmented treatment of certain subjects of major importance. The heart is dealt with in three widely separated sections (and the terminology used diverges considerably from current usage.) At first one is given to understand that the placenta is an organ for food extraction alone. Towards the end of the book, between sections on heart and stomach, one learns of the placental barrier. Finally, ovarian and menstrual cycles, meiosis and gametogenesis are not treated at all, a fault which a future edition will doubtless remedy. Nevertheless, even in its present form, this book is well worth its price.

MURRAY BROOKES.

AN INTRODUCTION TO GENERAL VIROLOGY.

By Thomas M. Bell, B.Sc., Ph.D., pp. 284. Heinemann Medical Books, Ltd. *Price* 35*s*.

This book claims " to provide a short up-to-date account of virology for the undergraduate . . . " and in the space of some 260 pages, it achieves its purpose admirably.

The keen medical student will find in it all the information he requires, including brief outlines of technical methods. Those training in virological work can find details of these methods from the extensive references given after each chapter.

The ordinary student, on the other hand, will be pleased to know that there are only about 10 pages to each chapter, which is very convenient for filling the odd 10 minutes. The reviewer feels that no student could safely sit an examination in pathology unless he has read at least the first eight and last six chapters of the book, dealing with the general properties and classification of viruses, bacteriophage and epidemiology.

A reprint will almost certainly be needed before long and the publishers should take the opportunity to rectify the few minor blemishes: split infinitives on page 33 and page 159; to replace what appears to be Blood Group nought by a proper O on page 226.

The student would also profit enormously if a glossary of abbreviations was supplied on a fly-leaf *and especially on a book-marker.* It is a little unrealistic to expect anyone to pick up a technical shorthand notation like F.M.D.V., E.M.C., H.E.K., C.P.D., etc., at the first meeting.

And is there any possibility of publishing a cheaper edition as a paper back?

E. H. BAILEY.

PSYCHIATRIC NURSING AT GUY'S HOSPITAL

by

Anne V. Moss

From the commencement of the Hospital, Guy's nurses have contributed to caring for mentally ill patients, twenty of whom, both men and women, were originally given refuge in the "Lunatick House". This was a separate building erected within the grounds of Guy's. Fifty years later, a new "Lunatick House" was built in an effort to keep the patients, now all women, "clean and vermin-free". The nursing establishment at this time was one resident Sister and four nurses.

Edward Wakefield, in a statement made in the House of Commons in 1815 on the State of Madhouses in England, gave a description of the conditions in which these patients lived. He commented on the bedsteads for wet patients, which were lined with lead and sloped to one corner. These patients were nursed between straw and blankets, the straw being changed daily. The clean patients slept between sheets which were changed fortnightly. One quarter of these patients were subjected to some form of physical restraint, usually iron chains or leather straps, and it was not until 1851 that William Gull, first Resident Physician to the "Lunatic Wards", succeeded in abolishing all forms of mechanical restraint from Guy's. Records concerning these patients include mention of recreational activities such as trips up the river, and one patient is known to have spent at least 53 years in the "Lunatic House". This latter is surely some recommendation for the nursing care she received.

The "Lunatic Wards" were closed by Act of Parliament in 1860, but some mental nursing continued in the general wards where psychiatrically orientated physicians, such as William Gull, admitted and treated the mentally ill. One feat of mental nursing worth recording at this time was the four-hourly tube feeding, for five years, of a clergyman in depressive stupor. This gentleman recovered.

The use of the "Strong Room" where porters, not nurses, cared for a few disturbed men, was a rather unhappy episode in the story of mental nursing at Guy's. However, with the opening of the York Clinic in April, 1944, psychiatric nursing became established in its own right within the hospital. Trained and student nurses were transferred from the general wards to staff the psychiatric unit, and a post registration mental nurse training programme was commenced —initially in affiliation with Bexley Hospital, but latterly in affiliation

with Holloway Sanatorium as well. This was the first mental nurse training scheme of its kind to be started within a General Hospital in this country. Initially a two-year training, in 1955 it was reduced to eighteen months.

At this stage it might be advantageous to examine a few aspects of psychiatric nursing, noting changes which have occurred during the past two centuries.

Originally, all mentally ill patients admitted to Guy's Hospital were certified as "incurably insane", treatments were infrequent and ineffective, and the nurse was principally concerned with the provision of the physical requirements for the patients over a period of many years. In fact, she created an environment in which the patient would remain for the rest of his life. Now progress has reached the point where short-term admission and active treatment are routine, so emphasis has shifted from provision of a place in which to live and die to the creation of a therapeutic atmosphere where a sick patient may respond to treatment and look forward to going home again after a short sojourn in hospital. In 1783, as no provision had been made for the unlikely eventuality of patients recovering in the "Lunatick Wards", permission, from the Governors, had to be sought before a recovered patient could be discharged. Now, patients are admitted to the York Clinic informally, as elsewhere in the hospital, and the custodial role of the psychiatric nurse has gone, together with the chains and locked doors.

The establishment and maintenance of close liaison with other members of the therapeutic team is an essential pre-requisite to all nursing. Especially is this necessary in psychiatric nursing where the patient, by nature of his illness, may have difficulty in making known his needs and wishes. For this reason it is of the utmost importance that communications between all who care for him should be well established, and to a large extent the onus of establishing such relationships rests with the ward hostess—the nurse.

The nurse must accept all patients as they are, and her attitude, as directed by the psychiatrist, must be consistent throughout her care for them. She must be prepared to listen, accept bizarre behaviour, but prevent the patient from doing anything which is likely to harm himself or others. As disturbances of behaviour are frequent signs of mental illness, these must be dealt with in such a way that the patient does not feel rejected nor the nurse distressed. Should either of these events occur the morale of the ward may be lowered and the process of healing delayed. In this context it is well for the nurse to remember that patients are usually far more frightened by their own strange and unpredictable behaviour than is anyone with whom they may come in contact. Composure and acceptance on the part of the nurse do much to allay this fear. In 1856, John Conolly wrote that the nurse was entrusted by the physician "to control the violent without anger; to soothe the irritable, without weak and foolish concessions; to cheer and comfort the depressed; to guard the imbecile and the impulsive,

and to direct all". This is all equally applicable today. Nor should it be forgotten that attention must be paid, by the nurse, to the relatives of these patients who have often suffered considerably.

Observation of patients is necessary to provide a guide to diagnosis and an indication of response to treatment. The nurse spends more time with the patients than any other member of the therapeutic team and it is her responsibility to notice and report changes in sleep, behaviour, mood, speech and personal relationships, and to provide an accurate account of how the patient spends his day. She must observe in such a way that the patient does not feel that he is being spied upon, but rather that he is in safe hands and among people who are interested in the way he functions, or does not function, as an essential preliminary to improving his health.

As with all types of nursing the psychiatric nurse is required to carry out specific treatments as prescribed by the medical staff. Briefly these include assisting with physical treatments such as electroplexy, administering appropriate drugs, and sometimes persuading unwilling patients to accept these, supervising and encouraging the anorexic patient with her diet, assisting with the deconditioning of travel phobic patients, and with the rehabilitation of leucotomised patients, and providing constant nursing care for the patient with suicidal intent.

The nursing of mentally ill patients within a General Hospital framework is now becoming an accepted pattern for those who require short-term in-patient treatment. The main limitation to nursing such patients at Guy's is lack of space, and in particular, lack of grounds. The patients in the old "Lunatick House" had a private garden in which to wander, but the patients in the York Clinic have only the noisy, overcrowded Borough High Street for their outdoor exercise. This presents an inconvenience for patients who require more than a very brief admission, but is overcome to a large extent by various outings, organised and individual, and week-ends spent at home. The advantages are considerable. The wards are small and homely, and the proportion of nurses to patients is much greater than in most mental hospitals. This enables the nurse to give more individual care to each patient. The separate rooms and cubicles afford sufficient privacy for patients not to be disturbed by their neighbours and enable treatments to be carried out in the familiar privacy of the patient's own bedroom, rather than in a strange, communal treatment room.

A large part of the nursing in the York Clinic is performed by student general nurses, each of whom works for eight weeks in the Clinic. During this time she is taught the basic principles of psychiatric nursing. In return she brings her own essential contribution of enthusiasm.

NURSING SECTION

Guy's Nurses' League

ANNUAL GENERAL MEETING

On Wednesday, May 11th, 1966, the Annual General Meeting of the Guy's Hospital Nurses' League took place in the Physiology Theatre at 3 p.m.

The Chairman, Miss F. Taylor, welcomed all members, and a special welcome went to the President, Miss E. E. P. MacManus, O.B.E., who recently celebrated her 80th birthday. Tributes by the Chairman were paid to the Honorary Officers:—the Honorary Secretary, Matron; the Assistant Honorary Secretary, Mrs. A. Blackburn; the Treasurer, Mrs. J. B. Blaikley.

The Honorary Secretary presented her report. Matron welcomed all members present. In her report Matron mentioned the changes that had taken place during the past year. The new tennis court; the block of 21 flats in Sarah Swift House, Kipling Street, built at a cost of £72,000, paid by the Governors from the Endowment Fund; the Bloomfield Clinic; the Paediatric Psychiatric Unit for Out-Patients south of New Guy's House.

Matron congratulated the following: Miss Mollie Farnsworth (Guy's 1952), appointed Matron of Harrogate General Hospital; Miss Myra Calvert (Guy's 1944), Cosmo and Mabel Bonsor Scholarship award 1966—£150 to assist with her expenses entailed as a Student of the Middle Temple; Mrs. V. Goodman (née Darwin) (Guy's 1956), elected President of the Royal College of Midwives from June 1966; Dr. Margaret N. Lee (Guy's 1944), awarded the Doctor of Education Degree, Columbia University, to take up an appointment as Associate Professor at the University of Windsor, Ontario in July 1966 (the first time this has been awarded to a British trained nurse).

The Acting Superintendent, Mr. R. J. Cann, gave the customary Superintendent's report on hospital events and progress in the last twelve months.

Mr. Cann referred to the progress on the plans for construction of the Tower Block. With reference to the upgrading of the Nurses' Home, Mr. Cann spoke of the new idea for decor, copied from one of the shipping lines to diminish the amount of decoration and cleaning to a minimum. Plastic surfaces around window frames, etc., dispense with the necessity for paintwork. The outlay is in the region of a quarter of a million pounds, paid for by the Endowment Fund. The Endowment Fund will eventually be rebuilding the West Wing in the front court, including the Chapel, Superintendent's House and Matron's House. The Chapel roof is unsafe and the rooms above have been closed to nurses accommodation; and in the course of the next few months the Chapel roof is almost certainly going to be supported by two rather unsightly beams.

Mr. Cann mentioned the integration with Guy's of New Cross General Hospital, St. Olave's Hospital and Dunovan Home. As a gesture of friendship the Endowment Fund made certain amounts of ready money available to do items of building or improvement in each of these areas.

The vote of thanks at the closing of the Annual General Meeting was proposed by Miss Dorothy Smith (Guy's 1919—Matron 1943-56), and seconded by Major M. Bridgewater (Guy's 1943).

The Salmon Committee Report

In July, 1963, the Salmon Committee was set up to "advise on the Senior nursing staff structure in the hospital service (Ward Sister and above), the administrative functions of the respective grades and the methods of preparing staff to occupy them".

This bulky report has now been published and is a highly complex document which will go a long way towards putting nursing in equal partnership with Medical and Lay Administration. It is felt that the nursing profession is incoherent in its administration. The profession should have sapiental authority —the right to be heard on all matters of nursing that are controlled by governing bodies, and the right to present the profession's concept of nursing authority.

The Salmon Report proposes three main lines of management in nursing— first line, middle and top line. The management will be graded from 10 for the most senior nurse in top management to 5 for the staff nurse.

Top management will have two grades:—

10. Chief Nursing Officer—C.N.O. (Principal Matron, Principal Tutor).
9. Principal Nursing Officer—P.N.O.

Middle management will have two grades:—

8. Senior Nursing Officer—S.N.O. (Senior Matron, Senior Tutor, Senior Midwife Teacher).
7. Nursing Officer. (Matron, Tutor, Midwife Teacher).

First line management, two grades:—

6. Charge Nurse. (Ward Sister, Section Sister, Midwifery Sister, Charge Nurse).
5. Staff Nurse. (Staff Nurse, Staff Midwife).

Until the present time hospital Matrons have been indistinguishable in selection to the size of their hospitals. The Whitley Scale grading being based on the number of beds and not the importance of decisions that have to be made.

The proposed structure outlines a broad scheme of systematic education and training for promotion upwards through first line to top management with the accent upon progressively increasing managerial skills. It is proposed that all nursing personnel—general, psychiatric, midwifery, should undergo the same managerial education, and together, for all should have the same opportunity to demonstrate their eligibility for the most senior posts where managerial ability and not nursing is the important criterion.

Management is seen as a speciality in itself, so that an officer trained in it knows how to work with other professional specialists in order to represent their interests and relay their knowledge to higher authority in the right way, and how to co-ordinate their way in such a way that policy decisions, rightly arrived at, are rightly executed, while at the same time the confidence of all concerned is preserved.

Present titles could be retained where appropriate to sex in middle and first line management, leaving a virtually new range of top management to attract the administratively minded nurse.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

Sister A. M. Shoan, S.R.N., S.C.M. (Beckenham Hospital) to Night Sister Nuffield House.

Sister B. Stair, S.R.N., S.R.C.N. (Guy's Hospital and Evelina Children's Hospital) to the School of Nursing Evelina Hospital.

S/N M. N. Tucker, B.S.C., nursing (Deaconess Hospital School of Nursing and Whitworth College, U.S.A.) to Cornelius Ward.

GUY'S TRAINEES

S/N C. D. Barnes to Addison Ward.

S/N E. A. Dow to Queen Ward.
S/N L. M. Milne to Theatres.
S/N G. A. Morley to Evelyn Ward.
S/N C. P. Young to Naaman Ward.

STAFF CHANGES

Sister P. Hunt to Night Duty.
Sister H. Smith to William Gull Ward.
Sister R. Thirlaway to Sarah Ward.

DEPARTURES

Sister S. J. Crawford to be married.
Sister G. Burnham to an appointment in Malawi.

SPORT

Guy's teams have continued to match success with success in most sports since our last issue. After the Athletics' Club win in the University Championships, Guy's athletes have played and won two matches, one of which was over Bart's and St. Mary's with a weakened team. Such continued good form raises our hopes in the U.H. Championships on June 4th. We wish the Guy's team good luck in their attempt to retain the cup.

The Cricket Club have also met with great success, winning their 1st Round Cup match against U.C.H. by 2.30 p.m. This was mainly due to fine bowling by Beacham and Davoodbhoy, particularly the latter, who took 6 wickets for 4 runs in 6 overs. In club matches the 1st XI thrashed Reigate Pilgrims and were unlucky not to beat the Strollers.

The 2nd XI had a walk-over in their cup match as U.C.H. could not raise a team. In other games the 2nd XI suffered their first defeat of the season with a weakened side, after two fine wins the previous week, in one of which one of the ex-sports editors of the *Gazette*, Andrew Proctor, scored a fine 76 not out.

The Tennis Club appear to be settling down into something like their usual form. Between going to press and publication, the 1st VI have played their first cup match against the Royal Free Hospital, we hope with success.

The Golf Club also will have had their first important match of the summer by the time publication comes. This was the London University Championships at Ashridge on May 23rd. There are several fine golfers in the club and one hopes that the next *Gazette* will show another Guy's success.

Finally we must congratulate C. W. Thorburn on his election as captain of rugby for next season. His skill and experience should help the 1st XV to a season as good as, if not better than last year.

Blue Awards for Summer Sports, 1965

CRICKET
J. Powell-Jackson .. .. Full Blue
D. B. A. Silk .. .. .. Full Blue
J. Butchey .. .. .. Half Blue

ATHLETICS and CROSS-COUNTRY
J. Morgan .. .. .. Full Blue
J. Domaingue .. .. .. Full Blue
D. Barford .. .. .. Half Blue
M. Bates .. .. .. Half Blue
E. Bowen-Jones .. .. Half Blue
R. Wilson .. .. .. Half Blue
B. Smith .. .. Half Blue

SWIMMING
J. H. Siegle .. .. .. Full Blue
K. McGlynn .. .. .. Full Blue
J. Holland .. .. .. Half Blue
A. Forbes .. .. .. Half Blue

RIFLE
D. Wardle .. .. .. Full Blue
D. Barker .. .. .. Half Blue

LAWN TENNIS
H. Sharp .. .. .. Full Blue
J. Newman .. .. .. Half Blue
P. Swiss .. .. .. Half Blue
J. Hopkins .. .. .. Half Blue
R. Machell .. .. .. Half Blue

FENCING
S. Bramwell .. .. .. Full Blue
R. Jones .. .. .. Half Blue
B. Hartley .. .. .. Half Blue
L. Cree .. .. .. Half Blue

LADIES' LAWN TENNIS
Anthea Sutron .. .. Full Blue

LADIES' SQUASH
Clare Stannard .. .. Half Blue

LADIES' HOCKEY
Lesley Sayles .. .. .. Half Blue
Mary Fortnam .. .. .. Half Blue

DIARY

CRICKET.

May: Saturday, 28th—Dragon Flies, 11.30 a.m. Home.
Sunday, 29th—Highland Court, 11.30 a.m. Away.
Monday, 30th—Crofton Park, 11.30 a.m. Home.
Tuesday, 31st—Bart's/or K.C.H. (2nd Round Cup).
June: Saturday, 4th—Teddington, 2.30 p.m. Away.
Sunday, 5th—Hampstead, 11.30 a.m. Home.

ATHLETICS.

June: Saturday, 4th—United Hospital Championships.
Wednesday, 8th—Heats for Sports Day.
Saturday, 11th—Sports Day.

LAWN TENNIS.

May: Saturday, 28th—St. Thomas' Hospital. Away.
Sunday, 29th—P.S.O.B.L.T.A. Home.
June: Wednesday, 1st—Imperial College. Home.
Wednesday, 8th—London Hospital. Home.

LADIES' FIXTURES.

May: Saturday, 28th—K.C.H. Home.
June: Saturday, 4th—R.D.H. Home.
Wednesday, 8th—L.S.E. Away.

REPORTS AND RESULTS

CRICKET

GUY'S v. STOICS

At H.O.P. Wednesday, 11th May, 1966

Result: lost by 4 wickets

Guy's: 156—4 dec. (Swift, 47 n.o.; Gillham, 45.)
Stoics: 160—6.

Guy's won the toss on a gloomy day and elected to bat. The openers started steadily until at the score of 18 Butchey was bowled. Silk followed soon after. Clark and Gillham batted well until Clark was out for 35, with the score at 76. Swift joined Gillham and they brought the total to 116 before Gillham was bowled for 45. Swift continued to bat well with Pearson, and when Guy's declared at 156 for 4 wickets he was undefeated with 47.

The Stoics started off briskly, but at 24 they lost their first wicket. However, some fine attacking batting by opener Nelson and No. 3 Manning saw them over the 100 mark.

Wickets fell steadily from this point onwards with Davoodbhoy taking 3 for 24 in a fine spell. However, the Stoics were not to be denied and they got home by four wickets with but five minutes left.

D. B. A. SILK

GUY'S v. THE STROLLERS

At H.O.P. Saturday, 14th May, 1966

Result: draw

Guy's: 170 for 6 dec. (Butchey, 83 n.o.; Powell-Jackson, 55.)
The Strollers: 153 for 9.

Last year the Strollers beat Guy's for the first time, and so it was with a new respect that they beheld their opposition. Runs came slowly at first the batsmen seemingly unable to dominate what from the pavilion looked like innocuous medium-pace bowling. An unfortunate misunderstanding in which two batsmen finished up at the same end did not contribute to the situation. Nevertheless, when Butchey was joined by the later batsmen he began to play like his old self and score at a respectable rate. When Guy's finally declared he was still undefeated and had played a valuable innings.

From the comments at tea, and the attitude of the opening batsmen the Strollers believed the task of scoring 170 runs in two hours quite beyond their capabilities. A sixth wicket stand of 68, however, enabled them to draw within striking distance of their target and foil any chance of a Guy's win.

J. POWELL-JACKSON

GUY'S v. REIGATE PILGRIMS

At Reigate Sunday, 15th May, 1966

Result: won by 90 runs

Guy's: 170. (Gillham, 44.)
Reigate Pilgrims: 80. (Pearson, 7 for 35.)

This match is always looked forward to as much as any in the cricket calendar. The splendid country situation, the pub just behind and a little square of third man, and the friendliness of the opposition contribute to a day which if granted sunshine is almost perfect. Absolute perfection demands winning the toss and occupying a deck-chair for the remainder of the morning while the Pilgrims toil in the heat and the nether regions of extra-cover.

Such was the setting. But all too soon we were rudely awoken by the familiar sound of falling bails as Butchey, in his inimitable way, tried to ease one over the mid-wicket boundary. Gillham gave some stability to the batting, and after eating more carrots than were good for him, was stumped just before he reached his crease and his fifty. The middle order batsmen were caught in trying to force the pace and at 138 for 9 a sense of foreboding had infiltrated the Guy's ranks. Steer and Beacham then proceeded to add 32 effortless runs for the last wicket; when can such a tail have wagged with such effect. Once, and only once, the immaculate forward defensive, which has become widely known as the standard guide to the young cricketer, was rejected for a carefully judged six into a neighbouring field.

Guy's were thus able to take the field with sufficient runs behind them to utilise their spinners freely. Pearson bowled admirably and, backed up by the best fielding of the season so far, finished with seven wickets to his name. Steer also kept an excellent length and this contributed to a most satisfactory all-round display.

The evening was culminated in the traditional manner, with valuable help from 12th man Ian Reekie.

J. POWELL-JACKSON

1st Round Cup

GUY'S v. UNIVERSITY COLLEGE HOSPITAL

At H.O.P. Tuesday, 17th May, 1966

Result: won by 9 wickets

U.C.H.: 34. (Davoodbhoy, 6 for 4.)
Guy's: 35 for 1.

Visitors to H.O.P. arriving at 2.30 p.m. were perhaps mildly surprised to see the Guy's eleven practising on the slip cradle or in various states of undress in the pavilion. In retrospect it was equally surprising that U.C.H. had elected to bat, for within half-an-hour of the lunch interval they had been dismissed for a modest 34. Seven of their batsmen were bowled out. This was more a reflection of the calibre of the bowling (or the inadequacy of the batting) than of the state of the wicket. So far this year the wicket has given no cause for complaint and one imagines that as it begins to resemble the excellent Guy's wickets of old, its reputation will soon be restored—which all goes to show what can be achieved by tender loving care and a soft word in the right quarter.

In the light of this, Davoodbhoy's bowling

was all the more remarkable. His figures read: 6 overs, 4 maidens, 4 runs, 6 wickets. Beacham bowled continuously from one end keeping a steady pace and direction and deserves more than the three wickets he claimed. The fielding, such as it was, could not be faulted. Butchey and Clark made light work in scoring the necessary runs off an opening attack which looked highly respectable.

In the next round Guy's are due to play the winners of St. Bartholomew's and King's. The former team were our conquerors last year and doubtless will prove tougher meat on May 31st.

The 2nd XI were granted a walk-over in their competition as U.C.H. could not raise a 2nd team.

J. POWELL-JACKSON

ATHLETICS

Match v. St. Mary's Hospital and Bart's

At Paddington Rec. 4th May, 1966

(Match won)

This match was the first following our victory in the University Championships. Only a limited number of members were available, and in view of what turned out to be an extremely wet and cold afternoon the competition was not very pleasant. Some events were cancelled due to the fact that there were no competitors from our opponents. M. Cheesborough and G. Voss proved valuable in a number of events and gathered enough points to give us victory by a very narrow margin. Generally, the standard of athletics was low and can probably be blamed on the weather.

Results (scorers only):

100 yds. D. Barford, 1st, 10.8 secs.; G. Voss, 4th, 11.0 secs.
High Jump. J. Domaingue, 1st, 5ft. 4ins.
880 yds. D. Choat, 3rd, 2 min. 6.4 secs.
Triple Jump. J. Domaingue, 1st, 39ft. 11ins.; M. Cheesborough, 2nd, 36ft. 10ins.
Shot. A. Ross, 1st, 43ft. 10¾ins.; D. Osborne, 2nd.
220 yds. J. Ross, 2nd; M. Cheesborough, 4th.
Long Jump. M. Cheesborough, 2nd, 18ft. 4ins.
Javelin. M. Cheesborough, 2nd, 124ft. 2ins.; G. Voss, 4th.
110 yds Hurdles. G. Voss, 3rd.

Results: Guy's 38 points, St. Mary's 37 points, St. Bartholomew's 31 points.

Match v. Goldsmith's College

At Loring Hall, Sidcup.

Wednesday, 11th May, 1966

Result: Guy's 132 pts.; Goldsmith's 128 pts.

Only six members were available for this match and before the match victory seemed remote. It rained for most of the afternoon and the freshly cut grass proved slippery, especially in the high jump and javelin. In the field events our entire strength was in the hands of R. Quinnell and G. Voss. D. Choat, D. Briggs and G. Waterhouse handled the distance events and also participated in the jumps with J. Domaingue. It was a rather tiring experience for most of us as members had to compete in three or four events each. Goldsmith's were not in a much better position as they had only eight competitors. With the 440 yards and 4 x 110 yards relay left we had two points in hand, and with the lack of sprinters our chances looked slim. However, Choat managed to win the 440 yards and Briggs was a good third; this secured our victory. We lost the relay but kept a four point lead to win the match.

U.H. Relay and Field Events Competition

Wednesday, 18th May, 1966

A large number of athletes had agreed to compete in this match, which was to be held in the afternoon at Finsbury Park. However, we were phoned the evening before that the match was to be held at 5.30 p.m. instead of 2.30 p.m. With a number of members having already made arrangements for the evening and having agreed to compete for the University team versus A.A.A. at 6.30 p.m., it was impossible to re-organize a team on Wednesday morning. We therefore had to cancel our entry. I apologise to members for any inconvenience caused.

J. DOMAINGUE,
Hon. Sec., G.H.A.C.

LAWN TENNIS

The start of the season was severely disrupted by rain, and five of the first six matches had to be cancelled. The one match which was played in April would also have been better cancelled as Guy's suffered a humiliating 9—0 defeat at the hands of Shooters Hill. However, most of our opponents had been playing throughout the winter and were not relying so heavily on fortunate mishits as were the Guy's team. It is to be hoped that this result will be reversed later in the season.

The first hot week-end of the season was devoted to United Hospitals and London University trials. Considering that Guy's are one of the stronger clubs in the University they were poorly represented with only one person playing in each event. However, Newman managed to surprise everyone by beating the top seed, and reaching the semi-final of the London University singles, which has still to be played.

Last week-end the first of the new fixtures against club sides was played and Guy's did well to draw with the Cumberland Club. Hopkins and Newman won their three rubbers, Sharp and Swiss provided the other success, and were only prevented from receiving a Guy's victory by one of the opponent's leaving for a pressing evening engagement! The next day Guy's won their first victory of the season beating Westminster Bank by five matches to four. Sharp and Swiss completed a satisfactory week-end by winning all three of their matches.

Next week-end is to be spent in Cambridge where the team hope to get the necessary practice before playing the Royal Free in the first round of the Hospitals' Cup on Wednesday. Fortunately the condition of the grass courts is considerably better than last year and the prospect of having to play a cup match at home is not as worrying as was the case last year.

J. NEWMAN

WATER POLO

GUY'S v. LONDON HOSPITAL

Away Monday, 9th May, 1966

Result: drew 4—4

This was the first game of the summer season. Guy's were 3—1 down after the first quarter, but soon got into their stride and the marking tightened—so much so that Guy's were well on top in the last two quarters.

Goals: S. Challacombe 3, A. Froom 1.
Team: D. Foulds, S. Challacombe, A. Froom, M. Adkins, K. Howard, M. Ham.

The Hormone House that Organon built

This is the idea that started the plan of the Hormone house that Organon built.

This is the researcher who had the ideas that started the plan of the house that Organon built.

This is the rat that was there at the start, as well as the cows, the sows and rabbits that enabled the researchers to probe the secrets of the hormones which built the house of Organon.

These are the workers who mixed the chemicals that joined up the molecules to make the bricks of the house that Organon built.

This is the doctor who found that the hormones helped his patients and prescribed the products of the house that Organon built.

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GUY'S v. BARCLAYS BANK

Away — Tuesday, 10th May, 1966

Result: lost 5—6

Guy's did not take advantage of their superior swimming strength in this game and due to some unnecessary defensive errors lost by the odd goal.

Goals: S. Challacombe 3, A. Froom 2.

Team: As in last game.

GUY'S v. BARKING TEE

Away — Wednesday, 11th May, 1966

Result: won 11—5

Guy's gained ample revenge for their defeat of last season. Barking are lacking in match practice, which is reflected in their rough style of play, but are strong, hard swimmers.

Froom and Challacombe played well in the middle linking attack and defence, and by breaking quickly up the pool scored nine goals between them. Foulds commanded his defence well and gave Barking few openings.

With more practice, especially in ball control, and with the inclusion of R. Jones, the prospects are bright for the U.H. Knock-out Cup later this term.

Goals: S. Challacombe 6, A. Froom 3, M. Adkins 1, O. Davidson 1.

Team: D. Foulds, K. Howard, A. Froom, S. Challacombe, D. Davidson, M. Adkins.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL
DEPARTMENT OF PHYSIOLOGY

Applications are invited from medically or dentally qualified men or women for the post of **Lecturer or Senior Lecturer,** commencing on or before 1st October, 1966. There are excellent opportunities for co-operation with clinical departments in the Medical and Dental Schools. Salary within the following ranges, according to qualifications and experience, with superannuation: Lecturer £1,895 to £2,630 plus £60 London Allowance, or Senior Lecturer £2,520 to £2,940, and then subject to review to £3,255 plus £80 London Allowance. Forms of application may be obtained from the Dean, Guy's Hospital Medical School, London Bridge, S.E.1.

HOUSE APPOINTMENTS

GUY'S HOSPITAL
June 1st, 1966

Assistant House Surgeons

To:—

Mr. Lawrie — Mr. M. E. Pembrey
Appointed for 6 months, the first 3 as A.H.S.

Mr. Glover — Mr. C. A. Soutar
Appointed for 6 months, the first 3 as A.H.S.

Mr. Brain — Mr. R. A. J. Spurrell
Appointed for 6 months, the first 3 as A.H.S.

Mr. Beard — Miss L. Rikard-Bell
Appointed for 6 months, the first 3 as A.H.S.

Assistant House Physicians

To:—

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. H. G. Sturzaker
Appointed for 6 months, the first 3 as A.H.P.

Dr. Hardwick, Professor Trounce and Dr. Deuchar — Mr. J. M. Richards
Appointed for 6 months, the first 3 as A.H.P.

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. P. K. Peace
3 months

Dr. Kauntze and Dr. Joiner — Mr. D. Tong
Appointed for 6 months, the first 3 as A.H.P.

Professor Butterfield and Dr. MacLean — Mrs. I. M. J. Mathias
Appointed for 6 months, the first 3 as A.H.P

Casualty Officers

Mr. T. H. Guerrier — Mr. D. B. Mathias
Mr. D. J. Hendrick — Mr. P. C. Pietroni
Mr. M. H. Jourdan — Mr. G. Smith

House Surgeon to the Surgical Unit

Mr. D. G. Gourley
6 months

House Surgeons

To:—

Mr. Eckhoff — Mr. T. N. D. Peet
6 months

Professor Atkins — Mr. N. W. D. Walshaw
3 months

Mr. Wass — Mr. W. T. Lamb
6 months

Mr. Blackburn — Mr. A. M. Morris
3 months

House Physicians

To:—

Dr. Mann, Dr. Scott and Dr. Bishop — Mr. M. S. Vernon
6 months

Dr. Hardwick, Professor Trounce and Dr. Deuchar — Mr. P. A. D. Williams
6 months

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. D. R. Bevan
3 months

Dr. Kauntze and Dr. Joiner — Mr. G. A. Pettitt
3 months

Professor Butterfield and Dr. MacLean — Mr. J. D. Rogers
6 months

Resident Obstetricians

Mr. A. I. Ogunleye
3 months

Mr. A. J. Robson
6 months

Gynaecological House Surgeon

Mrs. T. D. Pietroni
3 months

Throat and Ear House Surgeons
Mr. D. P. Leiberman
3 *months*
Mr. C. E. M. Lamb
6 *months*

Neurological House Physician
Mr. A. L. W. F. Eddleston
3 *months*

Orthopaedic House Surgeons
Mrs. C. J. Mowbray
3 *months*
Mr. C. A. C. Pickering
6 *months*

Dermatological House Physician
Miss A. Stokes 1.2.66—31.8.66

Genito-Urinary House Surgeon
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Mr. P. C. Smith (S.H.O.)
3 *months*
Mr. D. H. Evans
6 *months*

Children's House Physicians
Mr. A. R. M. Upton
3 *months*
Mr. B. S. Ricketts
6 *months*

House Physicians in Clinical Pathology
Mr. B. Read (S.H.O.)
6 *months*
Miss J. Parker
6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Mr. M. J. Elliott
3 *months*

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Mr. B. Anstee

House Physicians in the Department of Psychological Medicine
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R.M.O.s in Nuffield House
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Mr. J. McLeod 1.7.66—31.12.66

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Mr. T. E. J. Healey
3 *months*
Mr. M. B. Barnett
6 *months*
Mr. P. J. C. Baxter
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Mr. M. Suleman 1.2.66—31.7.66

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House Physicians to Dr. Mason and Dr. Cox
Mr. J. S. Gregson
6 *months* from 1.7.66
Mr. D. L. Ingram
6 *months* from 1.7.66

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Miss H. Hale
6 *months*

House Surgeon to Mr. Lewys Lloyd
Mr. P. Zelas (S.H.O.)
6 *months*

Gynaecological House Surgeon
Mr. S. M. Wood (S.H.O.)

Casualty Officer
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Mr. C. R. Sheard
3 *months*
Mr. R. A. Sturge (S.H.O.)
6 *months*
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6 *months*

Orthopaedic House Surgeons
Mr. A. H. Mobray (S.H.O.)
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6 *months*

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Mr. R. N. Chatterjee

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House Surgeons
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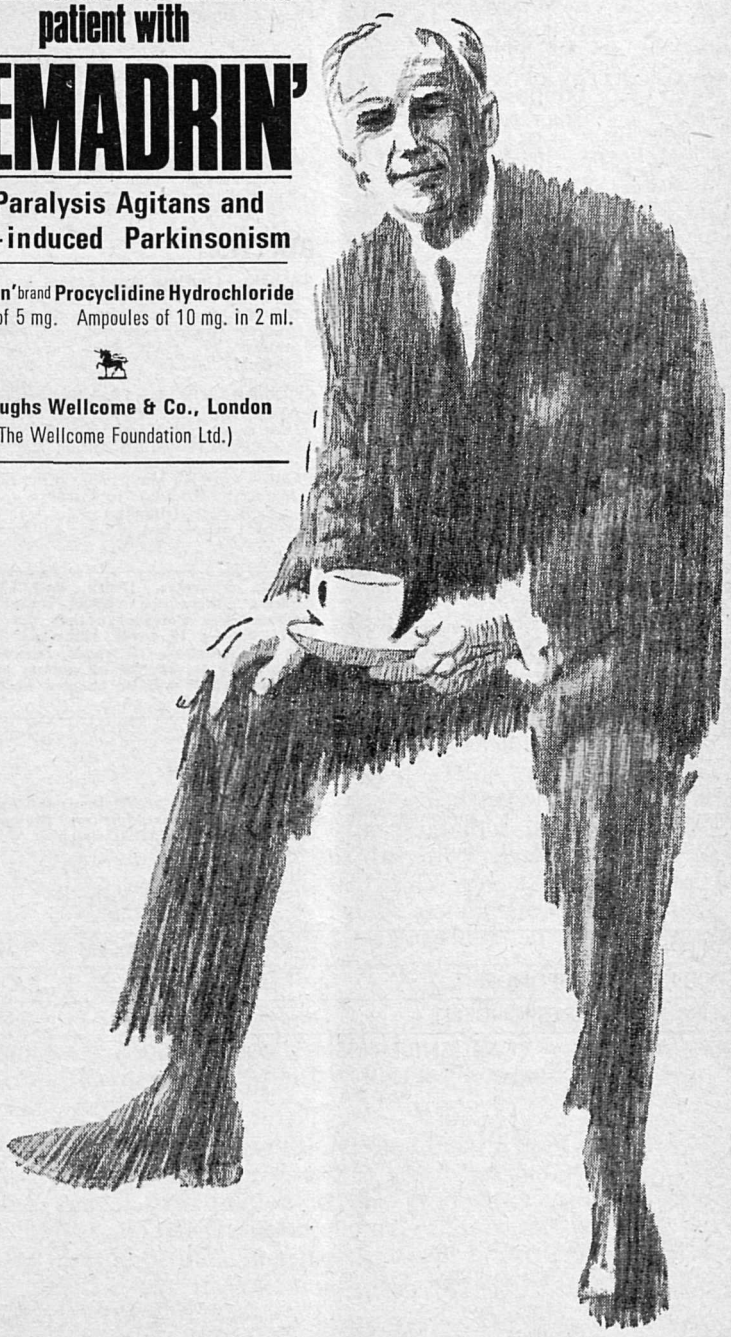

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CHANGES OF ADDRESS

CRABBE.—Mr. and Mrs. W. A. Crabbe, to 12a, Harley House, Upper Harley Street, London, N.W.1. Telephone: 01/935/9210.

WEBB.—Brien and Susan Webb are now living at "Lynwood", Stoke Park Avenue, Farnham Royal, Bucks.

BIRTHS

BROOK.—On 16th April, 1966, at the Jessop Hospital, Sheffield, to Pamela (née Barnardo, S.R.N.) and Dr. Simon Brook, a son, Andrew Simon, a brother for Claire. Present address 19, High Street, Penistone, Nr. Sheffield.

BUDGEN.—On May 11th, 1966, at The Queen Mary Maternity Home, Derby, to Gerry (née Ryan, S.R.N.) and Dr. Patrick Budgen, a daughter, sister for Adrian and Adam.

PAUL.—On 11th May, 1966, at the Beckenham Maternity Hospital, to Caroline (née Ryan) and Robert (Bumble) Paul, a daughter, Anna Louise—Just like the Milkman.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

ADOPTION

JAGO.—by Jane (née Hyland) and Dr. Francis Jago, of 27, Bar Meadows, Malpas, Truro, Cornwall, a son, Christopher John, now aged six months.

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
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FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2031

GUY'S HOSPITAL GAZETTE

PASSIM

How much is £1,000 Million

Last week the Ministry of Health announced its new ten-year programme for Hospital Building; promising, if it is economically possible, to devote an average of £100 million per annum to new hospital development.

The Press punch-line propaganda, however, in using a figure of £1,000 million, has almost certainly deceived most of the public and maybe even some of the profession, into feeling this is an enormous sum. And one feels that many, remembering the Review Body award of the week before, will be under the misapprehension that the country's medical services have "never had it so good".

Yet if this new building programme is viewed through the eyes of the recent B.M.A. report entitled "The Realities of Hospital Finance Today", a very different picture emerges. Firstly, if we compare this present budget for hospitals with what this country afforded before the war, we find that when taken as a proportion of the gross national income, we spent well over twice as much then as we do now. Also if we compare ourselves with other countries we discover that Sweden spends ten and a half times as much and what is even more of a shock even Czechoslovakia devotes a full eight and a half times as much.

Leaving aside considerations of prestige, however, and getting down to the actual implications of the programme, we are again in for a disappointment. For with the increase in population resulting in an additional requirement of 2,000 beds a year, at the approximate cost of £10,000 each, it emerges that if we extrapolate this new budget, the rate of replacement is such that many of our old and inadequate hospitals will not be changed for half a century. This is a depressing thought, and when coupled to the fact that the current ideas on meeting the country's doctor shortage is merely to expand the existing medical schools by 250 places and build a solitary new school, one realises that the men in the Ministry still have not read the writing on the wall.

All in all, we must treat the Review Body award and this new programme as only stop-gap measures before we can evolve a wider and more imaginative solution to this problem, a solution that is founded in fact and not in false economy. If, however, we settle back to another decade of blind smugness, we will be extremely fortunate to even maintain our present inadequate service, let alone improve upon it.

Quoth Gibbon?

The Pupils' Physical Society's symposium, "Medicine in International Co-operation", in honour of the centenary of Hodgkin's death, and Mr. A. Dickson-Wright talking on "Medical Students" of former years. Two apparently unrelated happenings about the hospital in the past few weeks.

Obviously, then, their relationship. Both were organized by the Pupils' Physical Society. Less than 5 per cent of the medical student population attended an afternoon of international medical perspective with speakers including the recently retired editor of the *Lancet*. The students had better things to do. (Not one member of staff in the audience to set an example, either—the man is gone, but how the memory of his hospital experiences lingers on.) A light-hearted talk on personal reflections and amusing anecdotes drew six times as many students (and one member of staff). Significantly fewer students had better things to do.

The non-syllogistic conclusion mirrors the oft-quoted, deprecated and indignantly defended apathy of the modern London medical student. Apathy towards the potentially full and wide-ranging education that is being offered at his hospital by teachers and the efforts of a few of his fellow-students. "If it is worthwhile it must be entertainment, and vice versa". While bitter is quaffed, playing cards nimbly dealt across Spit tables and Honor Oak tries are scored, the non-sporting clubs limp in minority and crumble in the majority. Quo vadis, Quodlibet? Energy is unfortunately misdirected when a furore is raised over an early closing of the students' bar one evening, and little else—did they manage to get it opened for a compensatory period on the Wednesday afternoon of the Hodgkin symposium?

But perhaps it's not apathy. Where else is it possible to qualify in medicine a mere four and a half years after leaving the protection and matey atmosphere of school? We appear to have progressed. We now have the antithesis of the "chronic" student of Dickson-Wright's medical school years—the "acute". So acute, in fact, that he appears to find very little time for obtaining much of value out of his short time in undergraduate education apart from what is gleaned from a few good, worn, condensed textbooks and the accepted traditional pastimes of a medical student. He is beleaguered constantly by that small, largely expatriot, group of students that seem to run most of the few active non-sporting societies or committees that still exist, with little effect. Is he really ready for a university education that is so generously being paid for by his parents and/or the taxpayer, is the question with which we are sadly faced.

We appear to be in need of a Billy Graham of the medical schools, a need for the continued preaching of the valuable fruits of a broader education in the receptive years to redeem that sadly large group of students who seek their salvation only through penitence before the narrow-minded Lucifer of Finals.

But all is not lost. We have regained the Cup.

We offer our congratulations to Mr. E. Arthur Williams, F.R.C.S., F.R.C.O.G., on his appointment as Consultant Obstetrician and Gynaecologist to the United Oxford Hospitals.

We must hasten to apologise for what we can affirm was a printer's error in the last *Gazette*, which attributed the whole of the first item under Passim to James Saunders. As many will have realised, Mr. Saunders was only responsible for the quotation at the beginning. However, he did help provoke what followed.

N. J. SHAH, F.R.C.S.

It is with deep regret that we report the death of Mr. N. J. Shah, who qualified at Guy's in 1945, and was cardiothoracic surgeon of the King Edward VII Memorial Chest Hospital, Warwick.

We offer his widow and two children our sincerest sympathy.

GUY'S DIARY

JUNE

20th	M.	1.00	Mr. CRABBE. Clinical lecture in the Anatomy Theatre. "Scoliosis".
21st	T.	1.00	Mr. BEARD. "Appendicitis".
22nd	W.	1.00	Professor W. E. HERBERT. "Clinical Cases". Dental Theatre.
23rd	Th.	1.00	Dr. POTTS. Clinical lecture in the Anatomy Theatre.
24th	F.	1.00	Professor BUTTERFIELD. Clinical lecture in the Anatomy Theatre.
28th	T.	1.00	Professor R. D. EMSLIE. "Fetor Ex Ore". Dental Theatre.

MR. T. T. STAMM

— *An Appreciation*

In 1935, Trethowan died and Stamm became assistant Orthopaedic Surgeon at the age of 30, with Lambrinudi as Senior Surgeon. In the same year, Stamm was appointed to the staff of the Royal National Orthopaedic Hospital. He quickly established his ability to follow the example set by his predecessor Trethowan and his senior colleague

Lambrinudi. For speedy simplicity and surgical skill in the operating theatre he followed Trethowan, who was one of the great orthopaedic technicians of his day. Stamm would, with great ease and speed, perform without assistance major orthopaedic procedures for which most surgeons would require at least two assistants. He despised the surgical tortoise, and showed little interest in the use of new and elaborate instruments. His surgical armamentarium consisted of a handful of old and trusted tools which would not have impressed the technicians of the present era.

For originality and inventiveness, Lambrinudi and Stamm had much in common. They thought along the same lines, and between them they made many contributions to orthopaedic surgery. Stamm's chief contributions were to the surgery of the hip, the shoulder and the foot. A prosthesis of his own design for arthroplasty of the hip was introduced in 1948, and was replaced in 1955 by his straight-stem prosthesis, the advantage of which he consistently emphasized. His scapular osteotomy, introduced in 1952, was a highly original procedure which proved to be most successful in the treatment of degenerative lesions of the rotator cuff of the shoulder, a group of conditions notoriously resistant to treatment.

In the surgery of the foot he built for himself a great reputation, and in so doing he followed the tradition established by Lambrinudi. His radical Keller for hallux valgus and his operation for the correction of the supinated forefoot were brilliant contributions to the surgery of the foot that would have been warmly approved by his friend and mentor, Lambrinudi. Stamm was responsible for the setting up of a shoe-fitting centre at Guy's, probably the only such centre at a teaching hospital in London, perhaps even in England, and with Lambrinudi he established a chiropody clinic which has been in action for many years. As a teacher and writer he was well known for his clarity. His "Guide to Orthopaedics", which has been very well received, is a small book designed to take the mystery out of orthopaedics for the general practitioner—which it does admirably.

Stamm's resignation at the age of 60 after 30 years of service to Guy's came as a surprise to many. During the last few years he had not, however, enjoyed the good health that his youthful appearance portrayed, and he decided that the time had come for him to change to a less exacting mode of life. For Tim Stamm this will not be retirement: he will continue to display the vigour and originality that marked his successful career as an orthopaedic surgeon, and those who worked with him at Guy's admire the astute management of his affairs which made this change possible. We wish him and his wife good health and happiness in their new home in Cornwall.

J.S.B.

GENETICS IN PSYCHIATRY

by

D. W. K. Kay

Department of Psychological Medicine, Royal Victoria Infirmary and University of Newcastle upon Tyne.

Since genetics is a biological science, it might be thought that it would have little to offer psychiatry, the subject matter of which consists largely of mental phenomena (such as abnormal thought processes, moods, motives, perceptions, habits and attitudes). All these, however, can be influenced, and sometimes profoundly altered, by the physical condition, whether this is a transient state of hunger or fatigue, a reversible delirium or intoxication, a permanent defect of structure or a constitutional characteristic. As J. B. S. Haldane pointed out in 1948, we can say that "John Smith is a complete fool because he cannot oxidise phenylalanine".

The physical changes underlying psychiatric disturbances may be acquired or inborn. Many inborn errors of metabolism are associated with mental subnormality, often of severe degree, and genetical studies have shown that different manifestations may be due to one disease (e.g. arachnodactyly), or that two or more diseases may present an identical clinical picture (e.g. retinitis pigmentosa). In adult psychiatry one can point to two conditions, Huntington's chorea and porphyria variegata, which genetic studies have shown beyond doubt to be true disease entities, appearing in the same form generation after generation. Although clear-cut examples of this kind at present constitute a very small part of everyday adult psychiatry, they justify further research into the nature of the physical changes associated with common conditions. Through genetical studies we may hope to distinguish metabolic disturbances which are primary from those that are secondary or symptomatic. Comparisons between empirical findings and conceptual models based on established genetic principles can provoke hypotheses and stimulate further research.

Genetics and Environment

The world-wide distribution and, so far as is known, the approximately similar incidence of the major psychiatric syndromes, such as schizophrenia and manic-depressive disorder, in widely different environments, suggests that they spring from causes lying deeply embedded in the human constitution rather than from exogenous

factors such as climate, diet, standards of living or hygiene, or exposure to infectious agents. But the nature-nurture controversy, expressed in crude general terms, now seems sterile. All human characteristics, whether normal or abnormal, must have their origins, in the final analysis, in interaction between genes and the environments in which they exert their effects. One has only to note the phenomenon of *cell differentiation,* during which cells of exactly the same genotype develop into the different tissues and organs of an individual under the influence of different chemical stimuli; or that of *sex-limitation,* which underlies those numerous sex differences that are not directly due to genes on the X or Y chromosomes, but to the action of hormones. Many of the clinical features of inherited disorders are probably the consequence of development and growth adapted to abnormal internal environments brought about by genes. *Rhesus incompatibility* between mother and foetus is a special case where the products of normal genes interact in a harmful manner.

Treatment of inherited diseases may be possible, not at present by altering genes, but by modifying the environment so as to suit that minority of the population which suffers from the effects of harmful genes. For example, in *phenylketonuria* and in *galactosaemia* treatment consists of eliminating certain dietary constituents (phenylalanine, galactose) which are quite harmless to normal people. "Acquired" disease, on the other hand, is due to gene-environmental interactions to which the great majority of people are potentially susceptible.

Learning Processes and Psychological Disturbances

Since much of human behaviour is learned, especially during childhood, it has often been pointed out that psychological resemblances between near relatives, e.g. mother and child, might arise from non-genetic modes of transmission. This explanation has been invoked to account for the familial occurrence of most of those psychiatric disorders that do not have a known physical basis. But it is not yet clear which of the abnormal emotional responses are capable of being acquired by learning or some other psychological process and which are not. Perhaps inborn propensities and learning processes reinforce each other in some families. Another problem is that generally only a minority of related people are affected. Why does one child, for example, "learn" a psychopathological trait, such as stammering, and not another? On the other hand the segregation of genes provides a ready explanation for differences as well as resemblances between members of a family. Much, however, remains to be discovered about the way in which constitution, and physical factors in general, affect the learning process. There is, for example, a certain amount of evidence to suggest that individuals who differ in temperament, as well as those who differ in intelligence, learn best when taught by different methods.

Methods in Psychiatric Genetics

Human families being generally small, and experimental breeding impracticable, methods requiring the pooling of data have been developed. The *family method* consists of the collection of groups of index cases suffering from the disease or syndrome being studied,

assembled with an eye to clinical homogeneity. Then after making the appropriate allowances for age-distribution, excess mortality, risk-periods and methods of ascertainment, the ratio of affected to unaffected persons actually observed among the close relatives is compared with the ratio to be expected on the hypothesis of dominant, recessive or sex-linked inheritance. In the "empirical" method, the aim is simply to compare the percentage of affected relatives with the corresponding incidence of the condition in the general population. When the disease is found to be significantly more common among the relatives than in the general population, there is a *prima facie* case for studying the causes of the family resemblances, which may of course turn out to be environmental, as in tuberculosis. This approach has led to a number of important epidemiological studies which have increased our knowledge of the incidence of various psychiatric disorders in whole populations, and have stimulated research into differential fertility and mortality, and into the effects of social change.

The *twin method* was first suggested by Sir Francis Galton (1875). The rate of concordance for the disease or trait among a series of MZ (monozygotic) twin pairs is compared with that among DZ (dizygotic) twin pairs. Since MZ pairs are genetically identical, while DZ pairs share on average only half their genes (like ordinary sib pairs) a disease which is inherited will regularly affect both members (or neither) of MZ pairs, but both members of DZ pairs in only a proportion of cases. Concordance rates in this case will be, therefore, much higher among MZ than DZ twins. For diseases which are wholly exogenous there is not expected to be much difference between the two types of twin, and the method thus provides a test of the degree to which a disorder is due to the action of genes. This twin method has been widely used in psychiatric genetics, and has shown that MZ twins tend to be more alike than DZ twins over a wide range of psychiatric and psychological conditions. To meet the objection that the environment may be more alike for MZ than for DZ pairs, comparisons have been extended to groups of MZ pairs reared apart from each other and those reared together. Some striking differences, as well as some extraordinary similarities, between individual pairs have come to light. A promising line of investigation is the search for relevant environmental differences, physical as well as psychological, between MZ pairs which are found to be *discordant* for disorders in which the concordance rate is high.

Genetics of the "Organic" Psychiatric Syndromes

It is both practicable and theoretically justified to distinguish those diseases associated with gross brain pathology or metabolic disorder from those in which no organic basis has so far been established (usually called the "functional" disorders). Apart from this distinction, the two groups differ in a number of ways. Whereas the organic disorders are individually very much rarer, are sharply demarcated from the normal, and have as a rule a clear-cut mode of transmission, the so-called "functional" group of disorders are relatively common, are often less sharply differentiated from the normal, and seem not to be transmitted according to the classical mendelian models. It is possible that these differences will prove to be of fundamental significance.

The organic group of conditions have a number of clinical features in common. These consist essentially of a failure or defect of *cognition* (memory, intellectual grasp), manifesting itself early in life as mental subnormality, and when it arises later as dementia. Usually the changes are irreversible and progressive. In diseases which appear later in life, such as Huntington's chorea, a number of "functional" syndromes or disorders of behaviour may usher in the disorder, but sooner or later they give way to typical dementia. The mental changes are not specific, and diagnosis depends on the physical signs, together with biochemical tests or chromosome studies. It hardly needs to be pointed out that inherited disorders are not necessarily congenital, and that they may appear after many years of normality. But from the clinical point of view they are conveniently sub-divided into those that make their appearance in infancy, in childhood, in middle life and in old age (Table 1). Probably, many genetic entities causing mental defect or disorder have yet to be identified.

The great majority of cases with *severe mental subnormality* (IQ below about 50) are caused by inherited conditions of this kind, or by exogenous causes, such as infections or trauma. In nearly all the inherited varieties there are associated somatic or neuropathological abnormalities of a fairly gross kind, and the subnormality is in fact only one aspect of a widespread disorder of development. In contrast, the milder forms of subnormality, discussed later, are generally free from physical abnormality.

An important sub-division occurs according to whether transmission is dominant, recessive, or sex-linked. All are rare or very rare. But studies of the biochemical abnormalities have already shed a great deal of light on enzyme processes and the way they affect development. (Tables 1 and 2.)

The main features of simple *dominant inheritance* are well known: in each generation, on average, half the members of the families are affected. In practice, however, this simple pattern is often modified because dominant inheritance is characterised by variability in the clinical picture (the "phenotype"), so that while one member of a family may show the complete syndrome another may show only one or two features. In *epiloia* (tuberose sclerosis) for example the affected parent may be epileptic only, but one or more of his offspring may show the whole range of pathological phenomena. In the condition known as *dystrophia myotonica* the clinical syndrome ranges from the muscular signs only to a condition with mental subnormality, frontal baldness, atrophic testes and cataract, as well as the myotonic symptoms. Occasionally the person carrying the gene may be quite normal. This gives rise to the state of affairs known as "partial penetrance" or "incomplete manifestation", producing pedigrees showing irregular dominance. Dominant genes that always cause severe effects early in life would soon be entirely eliminated from the population if they were not replenished by mutation; the frequency of mutation appears to vary at different loci, and is one of the factors that determines the incidence of rare diseases.

Table 1. Dominant and Recessive Conditions Associated with "Organic" Mental Disturbances.

DOMINANT		RECESSIVE		
Disease	Psychiatric State Mode of transmission	Disease	Subnormality	Tests for Heterozygotes
Achondroplasia (Chondrodystrophy)	Occas. subnormality; irreg. dominant	Phenylketonuria	Early, severe, unless treated	+
Acrocephalosyndactyly (Apert)	Subnormality variable but common; sporadic	Other aminoacidurias (e.g. "maple syrup" urine; Hartnup)	Early, severe	
Arachnodactyly (Marfan)	Subnormality variable; irreg. dominant	Galactosaemia	Early, severe, unless treated	+
Neurofibromatosis (von Recklinghausen)	10% subnormal; irreg. dominant	Retinitis pigmentosa (Laurence-Biedle-Moon)	Relatively mild; irregular	Mild symptoms may occur
Dystrophia myotonica	Subnormality mild or absent; variable expression, irregular	Gargoylism (Hurler) (*with* corneal opacities)	Early, severe	
Epiloia (Tuberose sclerosis)	Subnormality often severe; variable expression	Amaurotic idiocy (2 distinct forms)	Severe; infancy, childhood	Vacuolated lymphocytes
Huntington's chorea	Dementia and other adult disorders; regular dominant	Hepatolenticular degeneration (Wilson)	Onset in adolescence	+
Porphyria variegata	Episodic mental symptoms asociated with barbiturates. Any age; reg. dominant.	Spastic diplegia	Variable	
Cerebral atrophy (Pick)	Dementia age 45-60; irreg. dominant	Microphthalmia	Early, severe	
Senile dementia	Dementia age over 60; irreg. dominant (or ?polygenic)	Goitrous cretinism (Sporadic)	Early, severe	?Mild dysthyroidism
Epilepsy (rare cases)	Fits, onset late	Cerebellar ataxias (incl. Friedreich's)	Mild, later; variable expression	Isolated neurological signs
		Microcephaly (some forms)	Early, severe	

Simple *recessive inheritance* contrasts markedly with dominant inheritance. In general it produces diseases which (1) are more severe and more constant in manifestation; (2) show a sharper segregation of affected from unaffected members; (3) generally appear early in life. (4) The parents of affected individuals are clinically normal, but (5) are heterozygous carriers and (6) show an increase in consanguinity rate; (7) the sibs are affected in the ratio of 1 affected to 3 normal; and (8) the chances of an unaffected sib of an affected person being a carrier of the gene are 2 out of 3.

Another important difference is that, while dominant genes causing severe defects are very rare, the recessive genes causing severe defects are comparatively common. For example, the incidence of phenylketonuria is .00002 (1 in 50,000) and the frequency of the gene giving rise to the condition is .004 (0.4 per cent). This means of course that carriers of recessive genes causing rare diseases are very much more common than the disease itself. It has been estimated that every person carries as many as 3 or 4 potentially harmful recessive genes. The chances of any children of a heterozygous carrier being affected by the disease depend on the chances of his marrying another carrier. If he marries his first cousin there will be a 1 in 8 chance that the spouse will carry the same gene, and of course, on average the children of such marriages will be affected in the proportion of 1 to 3. Thus in the case of rare recessive diseases, a considerable increase of first cousin marriages between the parents is a regular finding, a fact which is useful as a criterion for recessivity.

Table 2. Sex-linked Conditions Associated with "Organic" Mental Disturbances.

SEX-LINKED CONDITIONS

Disease	Subnormality	Tests for Heterozygotes (Females)
Gargoylism (*without* corneal opacities)	Usual	
Microphthalmia (some forms)	Often severe but inconstant	
Muscular dystrophy (Duchenne type)	Mild, irregular	+ Electromyography
Various CNS degenerations.	Often severe	
Nephrogenic diabetes insipidus	Subnormality variable but usual unless treated	+
Anhidrotic ectodermal dysplasia (one form)	Mild, inconstant	Mildly affected
Pseudohypoparathyroidism and ?pseudopseudohypoparathyroidism	Subnormality frequent; dominant on X	

In *sex-linked conditions*, the disease is transmitted from unaffected female carriers to their male offspring, who are unlikely to reproduce. Neither sex-linked nor ordinary recessive transmission has yet been identified among the common psychiatric syndromes of adult life.

A knowledge of the laws governing the inheritance of dominant, recessive and sex-linked conditions is necessary for genetic prognosis; for example, when advising adoption societies, or parents who have had one abnormal child. For relatives, the mere enunciation of chances is not enough, and a psychotherapeutic approach is desirable. The final decision has to be left to the individual. For obvious reasons, genetic prognosis would be more accurate if carriers could be detected. Progress has been made in this respect in phenylketonuria, galactosaemia, Wilson's disease, and in nephrogenic diabetes insipidus. In some diseases, such as retinitis pigmentosa and in pseudo-hypertrophic muscular dystrophy, close relatives who are presumably carriers, occasionally show mild features of the condition.

Psychiatric Abnormalities Associated with Chromosomal Aberrations

It is convenient to describe these in a separate section from the major inherited abnormalities, since although the disorders to which they give rise are due to an excess, or deficiency, of genic material, their mode of inheritance does not necessarily follow mendelian laws, and major genes are not involved. Many of the grosser autosomal anomalies are lethal. At birth the frequency of the better known anomalies is approximately as shown in Table 3, the frequency among aborted foetuses being probably higher.

Table 3. Approximate Prevalence of the Commoner Chromosomal Anomalies. Per Thousand.

	Chromatin +ve males (XXY)	XYY males	Triplo-X females	XO females	Down's syndrome
At birth (live)	2.0	0.5	0.9	0.2	1.5
Chronic hospital psychotics	10.0	—	3.5	—	—
Hospital defectives ...	8.0	—	4.0	0.4	100.0
Security institutions	15.0	32.0	—	—	—

Anomalies of the autosomes produce more severe physical defects (skeletal, cardiac, renal, etc.), and generally more severe mental abnormality, than do anomalies of the sex chromosomes. *Down's syndrome* (monogolism) or *trisomy*-21 (Denver nomenclature) is by far the most important autosomal anomaly clinically, but reports of other anomalies, including the so-called "reciprocal syndromes" (e.g. "anti-monogolism" associated with *monosomy*-21), are now appearing. All of these seem, however, to be very rare. In Down's syndrome, severe mental subnormality is an almost constant feature, but patients with mosaicism (only some cells abnormal, mixoploids) seem to be less severely affected. It is usually held that these patients are free from the grosser forms of behaviour disorder and from psychosis, but their psychology is worthy of further study.

The four principle anomalies affecting the *sex chromosomes* are as follows: (1) Klinefelter's syndrome (XXY, chromatin-positive males); (2) XYY males; (3) Turner's syndrome (ovarian dysgenesis; XO females); and (4) Triplo-X females (XXX).

The physical features of *Klinefelter's syndrome* are fairly distinctive: small, atrophic testes, often gynaecomastia, poorly developed secondary sexual characters, and eunuchoid proportions. Psychologically, these patients are often shy, timorous and sensitive about their physical defects, and some are delinquent or alcoholic. These traits could be regarded as reactions to infertility and sexual difficulties, and their specific relationship, if any, to the chromosomal anomaly has not been clarified. Chromatin-positive males do not seem to be specially prone to homosexual behaviour, but appear to have some increased liability to mental subnormality and to psychosis. Males with the *XYY constitution* have been described only very recently. Interestingly enough they show features that may be directly attributable to the presence of two Y chromosomes, since they tend to be unusually tall and prone to violent outbursts of aggression. They have so far been located chiefly in special security institutions.

Among females with sex-chromosome anomalies (*XO and XXX*) there is at present little to be said from the psychiatric point of view. Patients with Turner's syndrome show only a very slight tendency to mental impairment. They have been described as docile and friendly. There appears to be some excess of triplo-X females in mental deficiency hospitals and perhaps some slight association with psychosis. Psychological and psychiatric studies of patients with chromosome anomalies are still in their early stages, and though it seems unlikely that they will directly illumine the causes of the great mass of psychiatric disorders, they may lead to better understanding of the relationship of bodily constitution to psychiatric abnormality.

The Functional Psychiatric Disorders

These comprise a very wide range of conditions, and include the *major psychoses* of adult life (schizophrenia and manic-depressive disorder), the *neuroses,* and the *personality disorders* which include *mental subnormality of the subcultural type.* Compared with the "organic" disorders, they are very much commoner, and show many abortive, transient, atypical and borderline forms; improvement or remission is often possible and even when deterioration does occur, as in some forms of schizophrenia, the intellectual faculties tend to be less affected than the emotions and the will. There is a tendency for the cases to concentrate within families and for concordance to be greater among MZ than among DZ twin pairs, but the relative importance of hereditary and exogenous factors, including experiences early in life, is still controversial. Some authorities believe that advances in the genetics of the adult psychoses await biochemical discoveries. It may be noted that porphyria variegata provides an example of a *remitting* disease with an inherited biochemical basis.

Manic-Depressive Disorder and Schizophrenia

Genetical studies have confirmed the basic distinction between these two conditions, originally postulated by Kraepelin on the

grounds of differences in symptomatology and outcome. The interpretations of the results of family studies have many problems in common. In the first place, it is found that in both conditions the risks among first-degree relatives (parents, sibs, children) which amount to some 10-15 per cent (except in the parents of schizophrenics), though definitely higher than in the general population (about 1 per cent), are lower than those to be expected on the hypothesis of simple dominant or recessive inheritance.

The risks among relatives are roughly proportionate to the closeness of the relationship to the index case, which is what one would expect on the genetic hypothesis. The majority of twin studies have found concordance rates to be higher among series of MZ twin pairs (50 per cent or higher) than among DZ twins (15-25 per cent). Moreover, in the rare instance of children of two parents affected with the same condition, the risk reaches 40-50 per cent. Allowing for the considerably reduced fertility of schizophrenics, especially males (fertility among manic-depressives is little affected), which accounts for the comparatively low risks among the parents of schizophrenics (2-9 per cent), the evidence is compatible with inheritance through a dominant gene with low penetrance in both conditions.

Taking the population incidence of schizophrenia to be 0.8 per cent, it has been calculated (Slater) that as many as three out of four carriers of the gene may never be psychotic, and that of those who are clinically schizophrenic, only three per cent are homozygous. This model has been shown to fit most of the known facts about family risks in schizophrenia very well, and would also seem in principle to be applicable to manic-depressive disorder. It is of interest to note that, in both these conditions, the near-relatives of index cases have rather often been found to show features that might be regarded as subclinical forms of these disorders, i.e. "cyclothymia" in the families of manic-depressives, and "schizoid traits" in the families of schizophrenics. There are, however, difficulties in defining these features precisely, and the exact proportion of relatives showing them is difficult to estimate. This line of thought suggests that what may be inherited is not so much the actual psychotic illness as some underlying predisposition, revealing itself clinically, if at all, as a deviation of personality. Attempts are now being made in several places to study more systematically the types of personality present among the near-relatives of schizophrenics, whether or not they are actually psychotic. According to this theory, environmental (not excluding intrauterine) factors would be expected largely to determine the actual outcome among the carriers of the gene. An interesting suggestion is that the carriers of the schizophrenic gene may possess some biological advantage, such as resistance to infections, which balances the low fertility of schizophrenic patients, and maintains the gene-frequency at a high level.

One of the problems in the functional psychoses is that of *heterogeneity*. Genetical studies have not yet brought to light clearly defined sub-groups, but it is probable that the clinical varieties of depressive illness (endogenous, involutional, neurotic) have somewhat different genotypes, with, however, a considerable amount of

overlap. Depressions arising after the age of 60 are less often hereditary than those occurring earlier.

In the case of *schizophrenia* also there has long been doubt whether the whole range of clinical varieties—typical and atypical, chronic, remitting, schizophreniform, and those of early or of late onset—could be regarded as one single entity. On the whole, family and twin studies have shown that when the illness begins early in adult life, especially when there is progressive deterioration, such as in the hebephrenic and some catatonic types, the risk among the relatives tends to be higher than in those types with onset later in life, with prominent paranoid features, or with good remissions. Recent twin studies in Scandinavia have also strongly suggested that the genotype is not identical in all varieties of schizophrenia. Whether the underlying predisposition is qualitatively or only quantitatively different from the normal needs to be much more thoroughly investigated. If predisposition turns out to be quantitatively different, this would naturally suggest *polygenic* inheritance (see below).

It remains to add that some authorities do not accept the genetic hypothesis at all, but see in schizophrenia, and even in manic-depressive disorder, the late-manifesting effects of early life experiences, particularly of relationships with parents who are emotionally disturbed (such as the so-called "schizophrenogenic" mother). At present these hypothesis are not well-defined and it is not clear precisely what experiences are to be regarded as specific. One unique report of MZ quadruplets, all of whom became schizophrenic, but with widely differing degrees of severity, suggests that the environmental factors influencing the appearance and manifestations of the disease may begin to operate at a very early age, perhaps even in *utero*, and that small initial differences in weight, vigour or intelligence may lead to differences in handling which in turn may set in motion ever-widening divergences in the development of personality. The study of environmental differences and of possible exogenous factors among pairs of MZ twins *discordant* for functional psychosis would seem to be particularly worth while. Schizophrenia-like states associated with amphetamine addiction, with some forms of epilepsy, with head injury and with chronic alcoholism, are already known.

Polygenic Inheritance and "Subcultural" Mental Subnormality

Polygenic inheritance is the mode of transmission of universally occurring, graded characteristics, such as height. When measured in a population, these characteristics are often found to be "normally" disturbed, e.g., in a Gaussian curve. The development of standardised intelligence tests has enabled "intelligence" to be measured and the results expressed in terms of IQs distributed on an approximately normal curve. Below the level of IQ of 45-50, however, the majority of instances of mental subnormality are due to pathological variants, both exogenous and inborn, as already discussed, and it is apparently these variants which cause the observed distribution of the IQ in the population to exceed the theoretical values at the lower end of the range. Mental subnormality of higher grades, on the other hand, is largely composed of those whose intellectual capacity falls in the

lower ranges of the normal distribution of intelligence. This type of subnormality is therefore physiological, or "subcultural", implying social or cultural failure.

Family studies starting from higher-grade subnormals have given results compatible with the studies of intelligence in general. On average it is found that the near-relatives tend to possess IQs about halfway between the index cases and the mean of the population (i.e. 100), the correlations between parent and offspring, and between sib and sib, being in the region of 0.5. At first sight this value fits very precisely with the genetic hypothesis of polygenic inheritance. It is in sharp contrast to the results of testing families containing low-grade subnormals, where the sibs are usually either themselves severely subnormal, or else have IQs that are distributed around the mean. Genetical studies have therefore lent support to the differentiation of subnormals into the two main clinical groups, the subcultural, with a population incidence of about 2 per cent, and the pathological, amounting to about 0.25 per cent and constituting most of the severe cases. Naturally there is a good deal of overlap in the range of IQs and the individual patient may be difficult to place.

But family studies have also produced evidence for assortative mating, that is for people of similar levels of intelligence to marry each other. The reported correlations between parents have indeed been surprisingly high, in the region of 0.5, and the implication of this is that the parent-child or sib-sib correlations ought to be *higher* (about 0.7) than they are actually found to be, if perfectly additive genes were solely responsible for intelligence. It seems that in Western societies about one half of the variance in intelligence is of genetical origin, though twin studies put it rather higher, at about 70 per cent.

The concept of "subcultural" defect suggests that it is related to the level of the prevailing culture. In our society, it is during the school years that the "incidence" of subnormality reaches its highest level in keeping with the notion that the demands imposed by the majority are beyond the reach of a small minority, who would not, however, be regarded as abnormal in less "advanced" communities. Suitable social measures and special education or training can enable a considerable number of subcultural subnormals to achieve a successful adaptation within society.

The Neuroses and Personality Disorders

Family and twin studies have indicated that relatives can resemble each other in type of neurosis, and that MZ twins are often remarkably alike in the basic features of their personality. Environmental influences are important, and the marked similarities between MZ twins in respect of some traits, for example, delinquency and homosexuality, may be a reflection of the tendency for people with very similar kinds of personality to seek out similar associates and subcultures, rather than the direct consequence of inborn propensities to specific forms of behaviour. The model of mental subnormality may well be useful in the neuroses and personality disorders, though at present we possess no quantitative measures, equivalent to intelli-

gence tests, to assess these other attributes of personality. Provisionally, we may suppose that they too are normally distributed in the population, and are determined by interaction of polygenes with environment. According to this model, at the extreme ends of the curve of distribution will be found the pathological varieties due to specific lesions, acquired or genetic. Acquired lesions forming the basis of pathological changes in personality have long been recognised; for example, brain injury and encephalitis. So far few specific single-gene syndromes have been identified, except for the very rare condition known as familial dysautonomia (the Riley-Day syndrome). One can, however, point to a number of examples where specific traits that may influence behaviour appear to be largely determined by genes; these include deaf-mutism (recessive), colour blindness (sex-linked), and musical ability; enuresis and word-blindness (dyslexia), both of which may be due to a dominant gene; left-handedness and stammering. In the area of definitely abnormal behaviour, the YY syndrome closely mimics, in the abnormal aggressiveness of these patients, the type of behaviour also seen in many psychopaths and some epileptics (where inheritance is probably polygenic).

Turning again to the cyclothymes and schizoid psychopaths that constitute the fringes of manic-depressive disorder and schizophrenia respectively, we may ask whether these also constitute the "visible" part of traits that are universally distributed, if we could only find suitable measures. The psychoses with which they are associated could then be interpreted as " threshold " phenomena, involving a step-like change into disease, (a similar interpretation has been suggested for epilepsy and for the malignant phase of essential hypertension).

While the "pathological variants" of neuroses and personality disorder constitute a minority of cases, the majority may be supposed to be "subcultural"; their failure lies in their social and personal relationships with others, or in their inability to conform with the demands of society. This line of thought suggests that people with different temperaments may be expected to adapt best to different environments, and that a community that offers a rich variety of subcultures may be less burdened by eccentric and other maladjusted citizens. Nevertheless for some widely deviant personalities it may be desirable to develop special methods of modifying their behaviour to fit them to take their part in society, and if these fail, to apply some restraint.

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NOTICES

Rugby Club A.G.M.

The A.G.M. of the Rugby Club was held in the Physiology Theatre on May 20th with the President, Mr. J. S. Batchelor, in the chair.

After the Secretary had read the minutes of the last meeting, which were duly signed, the Captain for last season, J. E. Davies, read his report. He said that the season just finished was the best Guy's had had for many years, climaxed by the cup win over St. Thomas's. A large part of the success was due to a wealth of talent in the intake of freshmen. He wished C. W. Thorburn, who had been elected captain for next season earlier in the day, continued success for the coming season. As a tribute to his leadership over the last season, Davies was presented with the ball with which Guy's won the cup, by the President.

N. James, the Ball Secretary, gave a short account of the financial aspects of the Ball Committee. He said that while there was at present a credit of about £50, this would soon be lost if we continued to have a Ball on the lines of this year's with two bands, etc.

The following elections for next year were then made:—

Secretary—P. G. F. Swift.

Junior Team Secretary—J. Payne.

Ball Committee Secretary—A. Proctor.

Mr. J. S. Batchelor was unanimously re-elected as President for the season 1966-67.

Rugby Club Dinner

A dinner will be held at the Royal Commonwealth Society, Northumberland Avenue, on Wednesday, 22nd June, at 7.45 p.m., to mark the return of the Cup to Guy's after a five-year absence. All members of the Rugby Club, past and present, are invited to attend. Tickets, at £2, are available from A. J. M. Procter, c/o The College, Guy's Hospital.

Hockey Club A.G.M.

The Annual General Meeting of the Hockey Club was held on Friday, May 27th. The following officers were elected for the following season:—

President: Professor Butterfield was re-elected.

Vice-Presidents: Professor Emslie, Dr. Scott, Mr. Gazet and Dr. Hunter-Craig were re-elected. Mr. A. Campbell was elected a new Vice-President.

Captain: M. Appleby.

Team Secretary: R. Kendrick.

Fixture Secretary: S. Cipps.

Second XI Captain: J. Salomon.

Third XI Captain: D. Silk.

Fourth XI Captain: A. Sutherland.

Theatre Club

This year's summer production is being staged in the Physiology Theatre from June 27th for 5 nights. The play is "Rain", by Somerset Maugham, and tickets will be available during the week preceding the play.

Art Society Summer Outing

The Annual Outing takes place this year on Wednesday, 15th June, when a party from the Society plan to visit Petworth House in Sussex, a late 17th century mansion partly decorated by Grinling Gibbons and containing one of the finest collections of paintings in England.

All members of the Hospital who would care to join this expedition are urged to add their names to the list on the Art Society's notice board, which is to be found situated on the 1st floor of the East Wing. Additional information can also be found arrayed on this notice board.

CORRESPONDENCE

The Trial of Steven Truscott

SIR, I am writing to use the courtesy of your columns to urge all of my colleagues, both at Guy's and elsewhere, to read "The Trial of Steven Truscott" published recently by McLelland in Toronto. To one who benefited greatly from Professor Simpson's excellent training in forensic medicine and among other things, on giving evidence in Court, this book provides a dramatic example of how an erroneous conviction appears to have been secured by faulty medical evidence. In this country at the present time, the case is to be reviewed by the Supreme Court of Canada and one can only hope that they pass a sounder judgment on the medical evidence for the prosecution and defence than the preceding courts appear to have done.

I think it would be extremely interesting to see a review by Professor Simpson of this book done for the *Gazette*. I think it is only by all medical men reading this book and taking some action that this terrible slur on Canadian Justice will be erased.

Yours, etc.,

C. R. NEVE, F.R.C.S.

April 29th, 1966.
J.F. Haszard Clinic,
Box 1239,
Kimberley, B.C.,
Canada.

Hodgkin Shunned Again

SIR,—It is a characteristic of Guy's men, Consultants and students alike, to make much of the noble heritage and tradition of this hospital. An event which honours one of the most illustrious of its staff, Thomas Hodgkin, would surely be received with approbation.

On the 25th May, the Pupils' Physical Society held a symposium in memory of Hodgkin on Medicine in International Co-operation. The following eminent members of the profession addressed the meeting: Dr. Goodman (Chairman, U.K. Committee, World Health Organisation); Dr. Dill-Russell (Deputy Medical Advisor, Ministry of Overseas Development); Sir Theodore Fox (Director of the Family Planning Association); and Dr. Barton (Senior Lecturer, Ross Institute of Tropical Hygiene). Topics covered included "World Population Control" and "The Effects of Imposing Medical Care." The Symposium was widely publicised and every senior member of staff personally invited.

Only twenty-nine students attended and not a single member of staff was to be seen. It is not enough to rest upon the laurels of the 19th century names of the Hospital, especially when we are unprepared to honour their memory, let alone continue their ideas through to this and subsequent centuries.

Yours, etc.,

COLIN B. BROWN.

Hampstead, N.W.3.

Miss Green and Miss White

SIR,—We should be most grateful if you would allow us through the medium of the *Gazette* to thank all the many friends who contributed towards the retirement gifts of Miss Jean White and Miss Marjorie Green. The response was extremely generous. We regret most sincerely if we have neglected to thank each contributor personally.

Yours, etc.,

THE DIAGNOSTIC X-RAY STAFF,
Guy's Hospital.

2nd June, 1966.
Guy's Hospital, S.E.1.

Till The Cowes Come Home

[We have pleasure in printing the following letter, which was addressed to Dr. Roy Goulding, Borgia Professor of Toxicology, Guy's Hospital for Incurables, St. Thomas' Street, London, S.E.1.]

SIR,—I am directed by my Lord Abbot to express his appreciation of your Poisoning Services. He has heard, however, that some of your practices are somewhat archaic, and he therefore ventures to draw your attention to the enclosed therapeutic remedy in the belief that it is unlikely that news of this should have reached you from over the water. He understands that supplies of both kinds of the raw material are abundant at St. Guy's.

Yours, etc.,

JACOBUS, Secretary.

27th May,
St. Jude's Monastery.

(THE ENCLOSED REMEDY)

Butler, physitian; he was of Clare-hall in Cambridge, never tooke the degree of Doctor, though he was the greatest physitian of his time.

The occasion of his being first taken notice of was thus: About the come-ing-in of king James, there was a minister (a few miles from Cambridge), that was to preach before his majestie at New-market. The parson heard that the king was a great scholar, and studyed so excessively that he could not sleep, so somebody gave him some opium, which had made him sleep his last, had not Dr. Butler used this following remedy. He was sent for by the parson's wife. When he came and sawe the parson, and asked what they had donne, he told her that she was in danger to be hanged for killing her husband, and so in great choler left her. It was at that time when the cowes came into the backside to be milk't. He turnes back, and asked whose cowes those were. She sayd (her) husband's. Sayd he, " will you give one of these cowes to fetch your husband to life again?" That she would, with all her heart. He then causes one presently to be killed and opened, and the parson to be taken out of his bed and putt into the cowes warme belly, which after some time brought him to life, or els he had infallibly dyed. There is a parallell storie to this in Machiavell's "Florentiac History", where 'tis sayd that one of the Cosmo's being poysoned was putt into a mule's belly, sowed up, with a place only for his head to come out.

NURSING SECTION

THE NURSING SERVICES

Glancing back—living now—planning forward

There is no shortage of literature and articles relating to the history of nursing at Guy's. All of this is both absorbing and fascinating to readers of several generations. Wilks and Bettany remind us of the earliest days, and record that "The governors of Guy's diligently set to work to complete their staff and on May 11th, 1725, they appointed a steward, a matron, eleven sisters, and eight nurses",—these last being at the princely sum of £16 each!

Guy's Hospital Gazette Committee published, in 1951, "Guy's Hospital, 1725—1948", which included a lucid account of nursing at Guy's by Miss Dorothy M. Smith, C.B.E., Matron, 1946—1953.

The Guy's Nurses' League Handbook records the history to the year 1959. These last seven years have seen immense change, and a detailed record will be published in the near future. In 1959, New Guy's house remained unfinished: Guy's House had yet to be restored: the teething problems of implementing a 44-hour working week for nurses were yet to be overcome. It may be of some interest to compare a few of the statistics of 1959 with those of 1966:—

	1959		1966
Sisters	97	... ...	117
Staff Nurses	68	... ...	180
Staff Midwives	23	... ...	17
Nursery Nurses ...	11	... ...	19
Pupil Midwives ...	12	... ...	15
Student Nurses	617	... ...	590
Preliminary Training School	52	Introductory Course: Nurses	75
Nursing Auxiliaries ...	—	... ...	16
Bed Complement ...	832	... ...	967

In November, 1965, Guy's Hospital became amalgamated with New Cross Hospital, St. Olave's Hospital, and the Dunoran Home. The School of Nursing welcomed this step forward with enthusiasm, and plans are now proceeding whereby student and pupil nurses of the three hospitals will share the educational opportunities which have arisen. A greater expansion for the nursing services lies ahead, and we are confident that with the co-ordination and industry which abound, still further growth of the Guy's Hospital School of Nursing is assured.

The most significant event in nursing education for many years occurred in 1965, when after nineteen years at Holmesdale, near Redhill, the Preliminary Training School was once more established at Guy's, and this made it possible to introduce the General Nursing Council's 1962 experimental syllabus of training in October. This allows for a far more realistic introduction to patient care than has previously been practicable. Throughout the eight-week period of the Introductory Course, new students are given a full opportunity to observe and partake in the twenty-four hourly nursing service. With the commencement of the new syllabus of training it became practicable to reduce the number of school intakes from four to three per annum, thus enabling the Guy's training to conclude at a period when the General Nursing Council State Final examinations are held. Recruitment and the calibre of selected students for entry are excellent. Seventy-five students now join the School of Nursing in September, January, and May. As from April 1st, 1966, the four-year training was reduced to three years and three months. This change brings the Guy's training into the current national pattern, and also ensures that nurses who wish to travel abroad when qualified, or have early marriage plans in view, will no longer leave their Training School without either their Hospital Certificate or their League Badge.

At present, a fair amount of complication is inevitable while everything is done to ensure that students who began their training prior to October, 1965, receive the maximum amount of nursing education which is possible, without a collision with the training planned for the students undertaking the new syllabus, and of paramount importance, without impeding the services to the patient. This situation can only resolve with time, and cannot hope to be completely overcome before October, 1968.

January 2nd, 1966, brought another vast upheaval for the nursing services when, at the direction of the Ministry of Health, a 42-hour week for nursing staff became obligatory. It was abundantly clear that implementation of a shift system of rotas of duty would be essential. This has necessitated a revision of the patients' day, and a great deal of re-organisation of catering and domestic services. It would be premature to give detailed comment at present. It must suffice to add that these changes have demanded great adjustment and re-thinking from the whole community. Tenacity and determination have been hugely required.

In these days an ever-increasing tide of paper flows through the gates of the hospitals, giving advice and comment and instruction, which can prove complex and at times contradictory! The nursing services of the country tend to become bewildered by these. The General Nursing Council advises on nursing education, the Royal College of Nursing endeavours to serve the profession and to protect it substantially from the threats of other organisations; and the Ministry of Health controls the purse strings and dictates the hours that the various channels of personnel may actually be employed. These activities continue amidst the sure evidence that during the last 30 years of this century there will be diminished woman-power available, a lower marriage age, still greater opportunities for the school-leaver, intensive medical research units requiring high staff ratios, and an increasingly ageing population needing institutional care.

Earlier generations undoubtedly overcame great problems. None need doubt that although the causes are very different from the difficulties of 1910 or 1940, we are not short of challenge in 1966!

I rejoice that the *Gazette* has now welcomed a Nursing Correspondent to its Editorial Committee. The nursing services need to advise and describe their various functions to the Guy's community. Only by accurate communication may this prove possible: only by co-ordination of effort with all staffs can the service meet the needs of this age. Let us ensure that those who come after us may have good cause to wish that they, too, might have shared in the opportunities of "the Sixties".

ANNE M. JOHNSON
(Matron, Guy's Hospital).

In the issue of May 28th, concerning the Salmon Committee Report, the Principal Tutor should have been included under Grade 9 and not Grade 10 as was printed.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

S/M G. M. Davidson (née Hardie), S.R.N., S.C.M. (Edinburgh Royal Infirmary) to Victoria Ward.

S/N E. K. Koliasnikoff, S.R.N., S.C.M. (Groot Shuur Hosp., Capetown) to York Clinic.

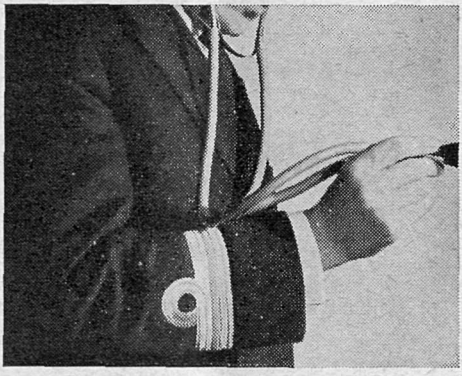
S/N E. R. Wood, S.R.N., R.S.C.N. (Manchester Royal Infirmary) to Diplock Ward.

DEPARTURES

C/N V. Joynes from York Clinic.
C/N S. K. Weeks from Caleb/Diplock.
S/N A. Petherbridge from Casualty.

How to bring more freedom into your life as a doctor.

Become a Naval Officer!



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2 During your pre-registration year.

3 As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

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The Medical Director-General of the Navy, Empress State Building, London, S.W.6. Dept. 26DN5,

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SPORT

With the cricket field, tennis court and golf course being blessed with fine weather, sporting activity has continued to prosper over the last two weeks.

The Golf Club took part in the University of London Championships on May 23rd at Ashridge. Scoring was difficult on a very windy day, and, with a long rough to increase one's difficulties, high scores were somewhat inevitable. The individual winner was R. MacLeod-Smith, a freshman from University College, who had rounds of 74 and 76 for a total of 150. Such scores were a fine effort and worthy of a winning score in such conditions. Two members of the Guy's Club finished second and fourth—A. B. Bevan-Jones, 154 (77 and 77), and D. Adams 162 (83 and 79) respectively.

The team trophy, the Beveridge Cup for the lowest aggregate for three players, also went to University College with an aggregate score of 476. Guy's finished second with an aggregate of 480, Guy's third scorer being D. Elliott with a score of 164 (83 and 81).

We must congratulate another member of the Golf Club, P. Ellis, on his election as Captain of the University of London Golf Club, and thus continuing a Guy's tradition of having the London Captain.

As far as Cup matches are concerned, Guy's had a bye in the first round, and their opponents in round two are not yet settled.

The Cricket Club have met with mixed success in their club matches, but when the result really mattered against Bart's in the second round of the Cup, Guy's had a resounding victory. Guy's batted first and scored 273 for 6 declared with Powell-Jackson and Silk the main scorers. Bart's were never in with a chance when they batted, and were dismissed for 84, giving Guy's victory by 189 runs. This was the second day in succession Guy's had made a big score, for in the traditional Whit Monday fixture against Crofton Park, Guy's had scored 240 for 5 declared. Crofton Park struggled to 124 all out to give Guy's an easy win.

The 2nd XI also had a good win in their cup match against Bart's. This year in the Junior Cup, each side has 40 overs, and hence a score of 200 in the first innings is well nigh unbeatable. Guy's batted first and scored 188 for 8 after 40 overs on a beautiful wicket at Chislehurst. Bart's struggled for the first 30 overs, so that the result was never in doubt, but over the last 10 overs they added another 70 runs.

The Tennis Club's first Cup match coincided with the only wet day and hence was postponed.

Sports Day is this week-end and it is hoped that the day blows fair. It is hoped that as many people as possible will attend what is always one of the year's most enjoyable social occasions. Not only are there the more serious events, but Bingo, a beer race, tug-o'-war, etc. for the less athletic types. A barbecue follows in the evening at H.O.P. Coaches will run back to Guy's afterwards around midnight.

Again we must congratulate the Athletics Club for winning the U.H. Championships last Saturday by 20 points, and thus retaining the Cup.

DIARY

CRICKET.

June: Saturday, 18th—Past v. Present. Home, 11.30 a.m.
Sunday, 19th—Madhatters. Away. 12.0 noon.
Monday, 21st— } Hospital Cup Final.
Tuesday, 22nd }
Wednesday, 23rd }

TENNIS.

June: Saturday, 11th—Midland Bank. Away.
Sunday, 12th—Park Langley. Home.
Saturday, 18th—Sundridge Park. Away.
Sunday, 19th—Lloyds Bank. Home.

GOLF.

June: Sunday, 12th—President's Match, Tandridge, 11.0 a.m.

ATHLETICS.

June: Saturday, 11th—Sports Day, H.O.P., 2.0 p.m.

CRICKET

GUY'S v. BIRMINGHAM MEDICAL SCHOOL

At H.O.P. May 21st and 22nd.

Result: won by innings and 5 runs

Guy's: 207 for 4. (Silk 66 n.o.; Powell-Jackson 61; Butchey 38.)

Birmingham Medical School,
1st innings, 63. (Beecham 3 for 13; Davoodbhoy 3 for 8.)
2nd innings, 139. (Davoodbhoy 3 for 34; Crafts 3 for 25.)

In the only two-day game of the season, Guy's won the toss and elected to bat first. Guy's batsmen were never in real trouble on an easy wicket and supported by dropped catches pushed the score steadily along to declare at teatime at 207 for 4. Powell-Jackson 61 and Silk 66 n.o. were the main scorers, with Butchey contributing 38.

Guy's were in a very satisfactory position at the end of the first day's play, having captured *eight opposition wickets for only* 48 runs. Their innings ended quickly the next day at 63, having lost the two remaining wickets cheaply. Beecham, 3 for 13, and Davoodbhoy, 3 for 8, were the main wicket-takers.

Birmingham Medical School were made to follow on with 144 runs behind. The opposition batsmen were never really on top at any stage and doggedly batted along to score 139 in their 2nd innings, taking almost four hours to make it. Guy's were therefore victorious by an innings and five runs and half-an-hour to spare. Davoodbhoy and Crafts taking three wickets each.

S. DAVOODBHOY

GUY'S v. INCOGNITI

At H.O.P. Tuesday, 24th May, 1966

Result: drawn

Guy's: 193—7 dec. (Silk, 77; Swift, 27 n.o.)

Incogniti: 32—2.

Guy's were given a sound start by Gillham and Thomson, putting on 30 for the first wicket. However, they were out in quick succession, and with Clark also being dismissed, it was left to Silk and Griffiths to retrieve the situation. Silk's fine knock, a most valuable one to his side, was only ended by a run-out, and with help from Griffiths, Appleby and Swift, Guy's were able to declare at 193 for 7.

At tea, the Incogniti had lost both their openers, and the game was evenly balanced when the rain, which had been threatening all day, finally put an end to play.

M. APPLEBY

GUY'S v. THE DRAGONFLIES

At H.O.P. Saturday, 28th May, 1966

Result: lost by 6 wickets

Guy's: 194 for 7 dec. (Butchey, 55; Powell-Jackson, 38.)

The Dragonflies: 195 for 4.

We were delighted to welcome back to H.O.P. the celebrated Dr. Reekie, fresh from keeping the score-books, we are told, of some of the best known and best-class clubs of the London cricketing "set". Indeed, any club of which Ian is not a member really is not worth joining!

On that day, however, the Foresters were deprived of his neatly recorded analysis and the Dragonflies were blessed with his leadership.

Powell-Jackson's phenomenal good fortune remained with him in that most important pre-match ceremony when Reekie had called for King George VI and Britannia—God bless her—smiled up at him from among the daisies. Accordingly, the Dragonflies took the field in the heat of the mid-day sun, resplendent in their brightly-coloured sweaters representing a multiplicity of cricket clubs with which Reekie has amicable associations. They did indeed match up to at least the first part of their dictionary definition, though perhaps their paunches and their movement in the field belied the rest—"brightly coloured insects with long slender bodies and transparent wings."

Guy's made a slow start, and the lunch-time score of 58 for 2 in 80 minutes was mediocre. However, Mrs. Chick's fine tongue and salad revived the dormant West Indian cavalier spirit in Joseph Butchey and he led the way after lunch in an onslaught on the bowling—so fierce was it that Reekie thought it judicious to withhold his "leg-breaks!!" for a future occasion.

A generous declaration left the 'flies even time to score the runs, and this they did with an ease which took the home side by surprise. Throughout the innings one Fitzgerald acted as an effective if inelegant sheet anchor, while others, particularly Ken Pettifer (67—his score, not age!) slayed the bowling mercilessly, particularly relishing the slow men. In fairness it

must be said that they did induce him to give ample chances to the deep field, who presumably adjudged that the spirit of the game did not warrant heroic catches! Or maybe their minds were already in the bar—or at the boat club dance . . .

Anyway, congratulations to our opponents on winning this most enjoyable game, and our thanks to Ian Reekie for bringing down the side. We look forward to seeing him again playing for the Past Guy's men v. the Present on Saturday, 18th June, when we very much hope he will bowl.

J. K. CRAFTS

GUY'S v. CROFTON PARK

At H.O.P. Monday, 30th May, 1966

Result: won by 116 runs

Guy's: 240 for 5 dec. (Chase, 82; Butchey, 77; Appleby, 42 n.o.)

Crofton Park: 124. (Davoodbhoy, 5 for 35.)

Guy's won the toss and elected to bat on a good looking wicket. Butchey and Chase started the innings off briskly, putting 50 on in the first hour. By lunch-time the partnership was unbroken; 128 runs being scored in 90 minutes. They continued at the same rate after lunch and the score reached 157 before Butchey was caught for a fine 77. Two quick wickets fell before Chase was finally out for 82 with the score at 172. A fine attacking partnership between Appleby (42) and Griffiths (21) enabled Guy's to declare at 240 for five wickets.

Crofton Park, obviously going for the runs, made a brisk 22 in even time before Clark caught and bowled one opener. He followed this up in the next over by dismissing the other opener in the same way. Davoodbhoy bowled Nankville at number 3 and Crofton Park were 25 for 3 at tea. After tea wickets and runs came slowly. It wasn't until 6.50 that Crofton Park were dismissed for 124, Davoodbhoy taking 5 for 35.

This was a fine win. The highlight of the game was the opening stand of Chase and Butchey; this, as far as we know, is probably a record for Guy's.

D. SILK

2nd Round Cup

GUY'S v. ST. BARTHOLOMEW'S HOSPITAL

At H.O.P. Tuesday, 31st May, 1966

Result: won by 189 runs

Guy's: 273 for 6 dec. (Powell-Jackson, 74; Silk, 58.)

St. Bartholomew's: 84.

In the light of last year's result, when Guy's were eliminated by Bart's, this was a most satisfying and rewarding win. The team's performances over the past weeks have shown that it was justly deserved. Nevertheless, in a game such as cricket where fortunes are so capricious, a team's record counts but little. It is this uncertainty which provides the fascination for the onlookers, and the extrasystoles of the contenders.

The day was scorching, and the wicket dry and parched. Adjacent wickets used during the previous week-end had been liberally sprayed which helped create the impression of an unduly heavy morning dew. The cursory observer might have thought there was something for two fast bowlers to exploit, and so Guy's were asked if they would bat. A quick wicket falling with only five runs on the board prompted an assurance from the groundsman that he had not misled his own team. However, the next hour redeemed him and the Guy's position as Butchey (31) and Clark (35) dealt effectively with all that was "thrown" to them. Silk and Powell-Jackson came together shortly before lunch with the score at 85 for 3, weathered the early storm, and then took advantage of the usual post prandial slackness in the field. The partnership added 114 runs. Appleby (34) wielded his bat (approved by the Design Centre and by his captain on this occasion) with gay abandon and enabled Guy's to declare at 273.

A long day in the field left its mark on the Bart's batting. Two valuable wickets were claimed in the half-hour remaining before tea; the second entirely due to Swift's opportunism in stumping the batsman from five yards behind the wicket. The bowling remained accurate and the wickets fell at pleasingly frequent intervals. It would be invidious to single out any one bowler—honours were shared equally among Butchey, Beacham and Clark.

Guy's now meet St. Thomas's in the semi-final at Cobham on June 9th. By the time this is read it will be known to a few whether Guy's have reached the final.

It is appropriate to mention here the achievements of the 2nd XI. This year the team is well above average and would give the 1st team a good run for their money. Playing against St. Bartholomew's in the 2nd XI competition, Guy's scored 188 for 8 in 40 overs (Griffiths 62). Their opponents amassed 142 for 7 in 40 overs. This victory takes them also into the semi-final against St. Thomas's to be played at H.O.P. on Wednesday, 15th June.

J. POWELL-JACKSON

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Registrar in the Dental Radiology Department**, to attend on six, five or three sessions per week, with duties commencing on 1st October, 1966. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Monday, 27th June, 1966.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the new post of **Full-time Lecturer in the Oral Surgery and Casualty Departments.** Salary in the scale £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535 with superannuation. Appointment to date from 1st October, 1966, or as soon thereafter as possible. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital, Dental School, London, S.E.1, not later than **Monday, 27th June, 1966.**

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

Applications are invited for the resident post of **Senior House Officer** for the six months commencing 1st August, 1966. The Unit, which is housed in the Maudsley Hospital, serves both Guy's Hospital and the Bethlem Royal Hospital and the Maudsley Hospital. Applications should be made by **25th June**, to L. H. W. Paine, House Governor and Secretary, Maudsley Hospital, Denmark Hill, S.E.5.

PASS LIST

SCHOOL OF PHYSIOTHERAPY

Chartered Society of Physiotherapy Final Examination, May, 1966

Collingwood, C. W.
Davies, B. R. A.
Edmunds, M. de Launay—Credit
Hammond, M. J.
Hendrick, S. K.
Lillington, M. E.
Martin, E. A.
Ridsdale, E. F.

CLUBS UNION

The following qualified L.R.C.P., M.R.C.S, April, 1966, and are Life Members of the Clubs Union.

Annan, William Victor,
11, Woodstock Avenue,
Golders Green, N.W.11.

Din, Sleem Feroze,
c/o Residents Flat,
Oldchurch Hospital, Romford, Essex.

Kirby, Robin Nicholas,
76, Wickham Road, Brockley, S.E.4.

MacLennan, Torquil,
56, Reigate Road, Ewell, Epsom, Surrey.

Richards, Jeremy Martin,
36, Colvin Gardens,
Barkingside, Ilford, Essex.

Snidvongs, Wongkulpat,
International Hall, Brunswick Square, W.C.1.

Soutar, Colin Andrew,
11, Orchard Gate, Esher Surrey.

Valentine, Brian Harvey,
65, The Avenue, Southampton, Hants.

Brown, Trevor Shaun,
Beaconsfield Arms Hotel,
Flamborough Road, Bridlington, Yorks.

Hadoke, Michael Fitzgerald,
Dudmaston, Bridgnorth, Shropshire.

Ingram, David Longden,
22, St. Augustine's Avenue,
Canterbury, Kent.

Pembrey, Marcus Edred, B.Sc.(Lond.),
Eastern House, Hurstpierpoint, Sussex.

Roberts, Ian Forrest,
Northwood, Harburn,
West Calder, Midlothian.

Rumpus, Marcus Frederick,
Pagham Mill Nurseries,
251, Pagham Road, Bognor Regis, Sussex.

Sturzaker, Hugh Gerald,
Sambourne, The Avenue,
Sneyd Park, Bristol, 9.

BIRTHS

FRANK.—On 18th May, to Vivien and Peter Frank, a daughter, Caroline Julia.

LISSENDEN.—On 24th May, at the Jersey Maternity Hospital, to Susan (née Wilson) and Dr. John Lissenden, a daughter.

MARRIAGE

WRIGHT—BAKER.—On 11th September, 1965, at St. Dunstan's Church, Cheam, David Wright to Margaret Baker, S.R.N., S.C.M. Present address, P.O. Box 24, Kasama, Zambia.

DEATH

GATHERGOOD.—On May 21st, 1966, Gerald W. Gathergood, F.D.S., R.C.S.Eng., aged 70 years, of Stottingbury Street, Upwey, Dorset.

Birth, Marriage, Death, and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2032

GUY'S HOSPITAL GAZETTE

PASSIM

Two important new developments for Guy's are about to take effect at the end of this year: rumours about their exact nature have been widespread for some time now and we have been anxious to inform our readers more precisely both about their details and their implications.

The New Plan for House Jobs

The first of these changes is to the present system of House appointments. The Medical Council has finally drafted and approved a completely new plan for the house jobs at Guy's, the main effects of which will be to increase the number of first six-month preregistration jobs, to change the casualty officers into post-registration appointments and to enable the announcement of all appointments to be made earlier than has previously been possible. These changes will not, however, be instituted before the December appointments, and although under the new system the newly appointed pre-registration housemen will have to leave Guy's after six months, the present housemen will not be effected in this respect. The Acting Superintendent will be publishing full details of this plan in the next *Gazette,* when we shall comment further.

Getting to Guy's via U.C.C.A.

The second change is in respect of the applications for entrance to Guy's. The Dean has submitted the following account of the new system which should clarify the situation and dispel the fear that has arisen that Guy's is no longer exercising any choice in the selection of new entrants.

"Together with the other London Medical and Dental Schools, Guy's have joined the Universities' Central Council for Admissions (U.C.C.A.). This means that candidates for entry to the Medical or Dental schools in October 1967 will not make direct application to Guy's as hitherto; they will send to U.C.C.A. in September this year a form obtainable from U.C.C.A. or from their school, completed by themselves and incorporating a report from their headmaster. On this form they state in order of their preference the six Universities or Schools to which they wish to apply. U.C.C.A will send on to us in due course copies of all the forms from the candidates who have placed Guy's on their list and from them we shall make our selection as in previous years. In other words, U.C.C.A. take no part in the actual selection of students; they simply process and distribute the application forms and inform candidates of the results of their application.

"It should be noted that when a candidate has been rejected it will not be possible for him to be re-considered (for the same year) in the light of any new evidence which may become available, so that anyone wishing to support a candidate must do so in future by the time the U.C.C.A. year starts in September."

As can be seen from this account, our entrance to U.C.C.A. makes no material change in the system but is simply a considerably more sensible way of handling the ever-increasing numbers of applications that are being made every year. It should, however, be especially noted by those used to the more flexible practices of the past, that this does mean that if they wish to support any applicant they must do so well in advance of the U.C.C.A. year, which for next year means before this September.

At Guy's, as elsewhere, the whole business of selection has long been a vexed issue. Criticisms have been made about the injustices of string-pulling and nepotism and about the low standard of Advanced level grading that is accepted. As to the first charge of there being too much nepotism, this would seem to be quite naïve and unfounded. For although it is a fact and something quite right and natural, that the school favours applicants with a tradition and family connections in the profession, this certainly never results in the blind selection of unsuitable candidates, for all are subject to a fair interview and have to pass the University's entrance requirements.

The second charge, about our low academic standards, however, is something that deserves more consideration. Although no one would suggest that to be a good doctor one needs to be erudite and scholarly, there is much cause to suppose that the best are in possession of a great deal of general ability. In measuring this elusive quality, the gradings at Advanced level, though certainly not perfect, are considerably better than nothing. It would therefore seem reasonable for Guy's to raise its requirements in future and instead of accepting bare passes ask for B and C gradings.

Where have all the students gone?

It is an enlightened administration that recognizes the futility of the systematic oral reproduction of the text-book, but there must be a similar enlightened attitude amongst the consumers. The decreasing demand for lectures has, however, given birth to some sorry transitional children.

The introduction of the voluntary basis of lunch-time clinical lectures is working well. Attendances have not dropped in the precipitous manner feared by some, while audiences are tending to become more appreciative of a good lecture. Curiously, however, the same cannot be said of many other lectures which still require the signature on the attendance list. Not confined to pure lectures, the lecture-demonstrations in the early morning are a spectacle far removed from those not so long ago days when even the galleries in

the Gordon Museum were crowded. This is not due to diminishing interest only, for the chore of investigations before the morning round as often as not consumes the time and many students are faced with the choice of attending the lecture and being late on the round, or missing the lecture.

While planning may well be in progress on the curriculum, some new stop-gap measures must be introduced so that education does not suffer in the interim. It is a sad state of affairs when an entertaining and highly informative lecturer has to thank the four or five members of his audience of final year students for coming along, as occurred about a week ago.

Teach In

The presses keep churning and saliva lubricates ever more efficiently with the net result that little progresses. Medical education holds as firmly as ever place of honour in this sorry Frankenstein aspect of modern society and technology. Thus the students at the Royal Free threw in their contribution a fortnight ago with a "Teach In on Medical Education". They drew a fair selection of topic experts and an even fairer selection of interested audience. In spite of numerous technical hitches and a slightly autistic chairman, an interesting though lengthy afternoon was presented with material continuously for four and a half hours. Interesting, yes, but within the limits that little new was said. Fascinating, too, that the Royal Commission representative, speaking unofficially, of course, imparted the impression that he and his fellow experts were rather more uncertain in their task than most others. It was all very comforting.

Two parochial notes, a comment to cynics and a suggestion to incurable optimists. Guy's acquitted itself in one speaker and more than six members of the Student Education Committee, with an interested member of staff in the audience. Secondly, the huge audience exemplified the value of the currently chic transatlantic public relations gimmick of "Teach in" rather than the apparently barren and old-fashioned terms of meeting and symposium—perhaps we will have in Guy's some New Frontiers for Great Societies.

The First Berry Lecture

At 5.0 p.m. on Thursday, the 30th of June, Professor Owen L. Thomas, of the Tuscaloosa Campus of the University of Alabama, is delivering the first Berry lecture. This lecture has been endowed by Dr. E. H. J. Berry, of Napier, New Zealand, to enable the Medical School to invite distinguished lecturers from overseas.

Dr. Berry is the middle of three brothers, all of whom qualified at Guy's. The elder, Mr. J. A. Berry, was a surgeon in Napier until his recent death, while the younger brother, Philip, is living in retirement in Kent.

We offer our congratulations to Mr. R. A. Hayward, a Governor of the Hospital, and Dr. Gavin Thurston, who qualified 1937, both of whom have been awarded the C.B.E.

It was recently announced by the University of London that the title of Reader in Preventive Dentistry has been conferred upon Dr. M. N. Naylor in respect of his appointment at Guy's Hospital Dental School.

It is with deep regret that we report the death of Professor Spurrell, who retired as Professor of Physiology only three years ago. A tribute to him will appear in the next *Gazette*.

GUY'S DIARY

JUNE			
30th	Th.	5.00	1st Berry Lecture. "Intracellular Canals". Professor O. THOMAS, University of Alabama.
JULY			
4th	M.	1.00	Prof. W. KAFKA, M.B., Professor of Paediatric Surgery, Prague. Clinical Lecture.
5th	T.	1.00	Dr. VAUGHAN. Clinical Lecture.
7th	Th.	1.00	Dr. HARDWICK. Clinical Lecture.
8th	F.	1.00	Dr. VALE. Clinical Lecture.
COMBINED ROUNDS.			
JULY			
1st			Professor TROUNCE and Dr. HAWKINS.

Mr. WALTER WILLIAM GILFORD

The death occurred with tragic suddenness on 5th May of Walter William Gilford while he was working in his garden, and shortly after operating at Pembury Hospital.

Walter William Gilford was the son of a doctor and related to Hastings Gilford. He went to Oxford with a mathematical scholarship and read physics and mathematics, obtained a first class degree and then worked on research into short cathode tubes. From Oxford he came to Guy's, where he taught physics and subsequently decided to read medicine. He qualified B.M., B.Ch. (Oxon.) in 1936, and later took the F.R.C.S. in 1940 and then the D.A. in 1941.

He was sent to Farnborough Hospital in 1940 and transferred to Pembury Hospital in 1941 as a surgical registrar, and spent the rest of the war working there on casualties as well as in General Surgery. Subsequently he was appointed Surgeon to the Hospital, and with the advent of the National Health Service, he became a Consultant Surgeon to the Tunbridge Wells Group of Hospitals. He was for some years a member of the Tunbridge Wells Hospitals' Group Management Committee.

Gilford was a man of outstanding surgical skill, wide knowledge and considerable experience. He was a skilful operator and in great demand by his colleagues for his help and knowledge, and, in fact, made himself available at any time to take part in consultations and in discussion. His friendly advice was always most carefully considered and invariably helpful.

He was a man of very wide interests, from games to music and always maintained his interest in physics and mathematics. His love of music was shared by his family, all of whom show very great talent, while his son has also inherited his mathematical ability.

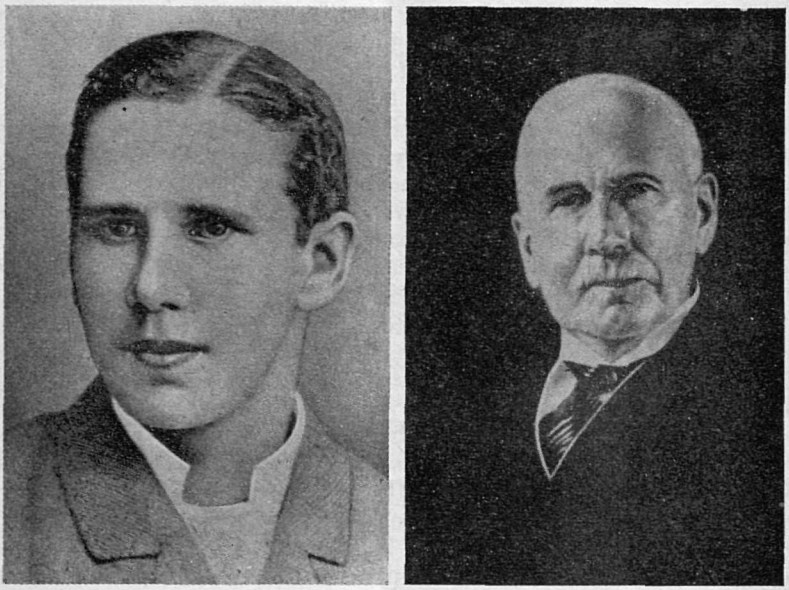
His loss to Pembury Hospital is immeasurable, and his ready help and ability will be sadly missed, not only by his colleagues, but by countless patients to whom he gave such splendid service.

Our sympathies go out to his widow and their three children in this sudden irreparable loss. E.D.G.

Arbuthnot Lane : Full Circle ?

By I. G. Schraibman, F.R.C.S.E., F.R.C.S.

Lately Registrar at the Royal Free Hospital, London



Two portraits of Arbuthnot Lane; on the left as a young man in 1873, aged 17; on the right in his old age.

(By permission of E. & S. Livingstone, Publishers, from "Sir William Arbuthnot Lane, Bt.", by T. B. Layton.)

The name Arbuthnot Lane inevitably conjures up the faded mental picture of a man who turned his back on the profession to preach a dogma to the glaring defects of which he was blind. It is my purpose to show that not only were his contributions to surgical thought so far-sighted that they have only recently borne fruit, but that even in his only major blunder he has been at least partially vindicated.

Lane's Real Contributions

Lane ascended the well-signposted steps to success with relative, but not dramatic celerity. He was not gifted with that open personality which immediately endears and had to rely on merit to progress; with this was allied a remarkable tenacity of purpose and capacity for hard work which may be attributable to his education in Scotland.

At each step in his career he turned his attention to the material with which he came in contact. It seemed that lessons he derived, while always useful and directly practical, were rarely strictly original. For instance, it was Lister who first performed internal fixation of the fracture (a patella) but Lane was drawn to this concept quite independently, and upon it he erected a new edifice of fracture management (Lane 1905). Medical historians take great delight in pointing out that So-and-So's syndrome or procedure or technique was actually described earlier by someone else. To whom belongs the credit—to the innovator who may have thought so little of his discovery that he did not consider it worth pursuing; or to he who realises the value of an idea (original or not), perfects and publicises it?

In addition to the above qualities, Lane had wonderful hands. They performed technical feats which dazzled his contemporaries, but seemed to act in some way independently of his conscious mind, because he could never teach as well as he could demonstrate. Thus he recognised no bounds to his desire to conquer disease nor did he readily accept any limits to technical feasibility, attributes which could have been disastrous in one less gifted.

His first published original thoughts resulted from observations he made on deformities of the skeleton produced in various occupations. He could deduce, for instance, that a spine showing cervico-dorsal scoliosis belonged to a brewer's drayman who carried barrels on his right shoulder; this delighted Oliver Wendell Holmes, who considered this and like exercises "the cleverest bit of anatomical detective study I have heard of" (Layton 1956).

His first surgical appointment was to the Victoria Children's Hospital, Tite Street, London. Here he was confronted by the unchecked ravages of middle-ear disease. To prevent pyaemia from septic thrombosis of the internal jugular vein he ligated this vessel. Here, too, he practised rib resection for empyema although this was not an original idea.

After appointment to the Surgical Staff of Guy's Hospital in 1888 as Assistant Surgeon he began to develop his technique of aseptic surgery. It must be recalled that surgical gloves had not yet been devised and Lane realised that the human skin could not be sterilised. With this system drilled into his associates and theatre staff, the way was open to the hitherto untrodden field of elective orthopaedic surgery. Lane at first wired fractures (as Lister had done with the patella) but later used screws and devised plates. In some of the published X-rays (Lane 1905) the fracture line is indiscernible.

One of Lane's major defects (which will be further discussed) was a reluctance to accept that ideas which he championed could have disadvantages; nowhere in his writing is there mention of the failures

of plating. There must have been many of these, however, for when his late detractors became his imitators they did not possess his rigid aseptic discipline. Lane would not accept that the tissue responses to the steel plates were inevitable, preferring to believe that these were all due to infection introduced by other, less scrupulous surgeons.

Parenteral infusion had first been used in a cholera epidemic in 1832 (Layton 1956) but Lane gave intravenous saline for haemorrhage after tonsillectomy based on the work of Leonard Wooldridge, a contemporary physiologist.

Although attempts had been made to resuscitate patients by cardiac massage, Lane was the first to achieve success; he massaged the heart per abdomen through the intact diaphragm. He was, however, original, in suggesting closed cardiac massage in children to take advantage of the compressibility of the rib cage in the young.

The credit for the first resection of carcinoma of the oesophagus with restoration of continuity by means of a local pedicle skin flap must belong to Lane (Lane 1911). The functional result was imperfect in that the patient had to be fed by a tube passed down the oesophagus although she could swallow her saliva. This operation ante-dated Wookey's classical description by 36 years (Wookey 1947).

One of Lanes enduring interests was in the repair of cleft palate and he made full use of mucosal flaps which even extended on to the cheek as far as the orifice of the parotoid duct.

To render a problem in mechanical terms is to make its comprehension easier, for such is the limitation of our thought processes. It was thus logical to suggest relieving the disability of a stenosed mitral valve by mechanical means. Lane had discussed the idea with a physician colleague, Lauriston Shaw, in 1890 though this only came to light in 1902 (Lane 1902) after another physician had mooted the idea. Shaw (Shaw 1902) wrote to confirm that he had indeed discussed the matter with Lane, but went on to admit, quite candidly, that he did not consider the procedure justifiable and had therefore not referred any patients to Lane. In passing, it is of interest to note that Lane had intended to use the transventricular route which is the standard procedure today.

Intestinal Stasis

It is not possible to determine, in retrospect, exactly how the seed of this concept was sown in Lane's thoughts; but the seed fell on fertile soil and matured rapidly into an obsession which displaced all vestige of objectivity, rationalism and self-criticism (Lane 1915).

Several factors formed the background to the concept that the toxins of the bacteria of the large intestine caused disease. It was partly a product of a mechanistic age; and the then current method of scientific teaching of autocratic pronouncements from on high, made it certain that when Lane achieved prominence, his dogmatism would ensure some support.

Further, Lane was unduly conscious of his own constipation. He remarked that he suffered severely from this disorder. The credit (if such it be) for the medicinal use of liquid paraffin was Lane's and

he administered it to himself with, he averred, a gain in weight of 1½ stones in consequence (Tanner 1946). There is no record that he ever contemplated undergoing colectomy for his disorder, presumably for lack of a sufficiently trustworthy surgeon.

In adversity Lane was sustained by a tenacious faith in his ideas. After all, the pattern of all his successes had been idea, practice, publication, abuse, acceptance. This sustained him in his fight to have colonic stasis recognised. He had some eminent colleagues in support. Metchnikoff, in fact, suggested the basis for the theory and his "La Vie Humaine" had undoubtedly influenced Lane. Further support was offered by Barclay Smith and Arthur Keith. Dr. Nathan Mutch, Lane's son-in-law, made a clear statement implicating colonic bacteria in the production of alimentary toxaemia, and purported to trace the precise biochemical pathway of this condition (Mutch 1915).

Thus the backdrop was in position and Lane needed no great prodding to "try the experiment". Undoubtedly his eventual monomania was sustained by some initial successes and it is possible that a concatenation of these in the early stages produced a spurious impression of a high overall success rate. For example, Lane described dramatic improvement after colectomy in an ataxic woman who, prior to her operation, was regarded as an imbecile.

The affair culminated in the mammoth debate held at the Royal Society of Medicine in March 1913, which occupied six evenings and in which sixty speakers participated. Lane had nothing new to add, but in summary claimed that intestinal stasis caused duodenal ulcer, cardiospasm, pancreatitis, carcinoma of the pancreas, gallstones, cholangitis, degeneration of the heart, arteries, kidneys and muscle; retroversion of the uterus, cystic degeneration of the breasts, carcinoma of the breast, goitres, high or low blood pressure and mental disease. In addition, tuberculosis and rheumatoid arthritis could not exist but in the presence of autointoxication.

Probably the majority of speakers were impressed by Lane's ideas and some sophisticated biochemical evidence was adduced to show that the products of bacterial action on faeces could be toxic. It was generally agreed that the by-products of protein degradation were the main offenders (Dixon 1913). Many commented on the part played by the liver in producing symptoms, but most assumed that this was due to cirrhosis consequent on absorption of toxins by the portal system. A physician (Hunter 1913) commenting on the effects of anaesthesia on the liver, stated that due to the depressed state of the liver after an anaesthetic, "the portal blood passes unchanged into the general systemic blood and we have presented . . . precisely the same phenomena producible experimentally (in Eck's fistula) by connecting up the portal vein directly with the inferior vena cava". W. Hale White (1913) was the principal antagonist. In the course of an effective debunking he made a remarkably prescient speculation. He pointed out that "there was strong evidence that an important function of the liver was to protect us from poisons absorbed from the intestines" and might it not be that alimentary toxaemia was a hepatic disease? (White 1913). Another speaker claimed that a copious motion might dissipate an attack of insanity. (Briscoe 1913).

This is precisely the point. It seems clear that some of Lane's patients were suffering from cirrhosis of the liver with portal-systemic encephalopathy (P.S.E.). In this condition, the products of bacterial action in the large bowel are not detoxified by the liver as they bypass it and enter the general circulation via the numerous portal-systemic anastomoses. That colonic bacteria are indeed the cause of this condition is shown by the fact that neomycin suppresses it in most cases (Sherlock 1963), and colectomy or colonic exclusion is also beneficial (v.i.).

It is postulated that one or two such dramatic successes would have convinced Lane of the truth of his theory and given his strong intuition, tenacity and autocracy enabled him to gloss over a large majority of results which were failures.

The Present Status of Colonic Exclusion

Portal-systemic encephalopathy is a troublesome feature in one-fifth (Walker 1959) to one-third (Read *et al* 1961) of patients who have undergone porta-caval anastomosis for bleeding varices and in a smaller proportion of cirrhotics who have not undergone operation. The majority of these can be controlled by a low protein diet and neomycin (Sherlock 1963). This regime is subject to the risk of development of superinfection of the bowel, of undernutrition (with oedema) and in a few, it fails to control the symptoms of P.S.E.

In 1960, Atkinson and Goligher reported dramatic improvement after colectomy in a cirrhotic with P.S.E. which could not be controlled by medical treatment. Latterly, it has been considered sufficient simply to exclude the colon from the faecal stream and perform ileo-rectal anastomosis (McDermot, Victor and Paint 1962). This idea has found ready acceptance at the Royal Free Hospital, London, where, until January 1965, 7 such operations have been performed (Dawson 1965); of these, two have been outstandingly successful, two have shown gratifying improvement and three have died, largely as a consequence of the poor state of their liver function.

Lane's Balance Sheet

Credit	Debit
Publicised rib resection for empyema.	PURSUED INTESTINAL
Perfected no touch technique.	
Pioneered primary plating of fractures, parenteral infusions,	STASIS BEYOND THE
safe colonic surgery,	BOUNDS OF CREDULITY.
internal jugular ligating for aural sepsis.	
Practised cardiac massage per abdomen.	
resection of carcinoma of the cervical oesophagus.	
aseptic surgery.	
Proposed mitral valvotomy,	
closed cardiac massage in children.	

Although the debit side of this balance seems to speak loudly, it can clearly not overbalance the credit side. Arbuthnot Lane's career will be viewed in proper perspective if it is realised that the credit side of his account represents the extent of our indebtedness to him.

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Acknowledgments

I am grateful to Professor M. R. Ewing and Mr. R. S. Lawson for their helpful comments and to Messrs. I. & S. Livingstone for permission to reproduce the photographs.

Obiter Dicta

Overheard at a European Dental Congress :—

"It's not that I'm against experimentation, and I've done some myself, but . . . . . ."

NOTICES

Art Society Autumn Exhibition

Another exhibition is to be staged early next term, at which prizes to the value of £3, £2 and £1 are to be awarded to the three best entries.

Members are urged to commit themselves to canvas during the summer vacation.

Debating Society

" The time has come, the walrus said, to talk of many things." Once again the Debating Society was doing just that, on Tuesday, 7th June, in the North Common Room, in what was very much a battle of the sexes with both sides talking of many things common and uncommon to both sides. The visitors' opening attack, from Digby Stuart Teachers' Training College (speakers, Miss Elizabeth Hare and Miss Frances Hardy) began with an explanation of the finer subtleties of female psychology employed and the practical attitude adopted in the war for mutual co-existence with males. This was countered by a careful historical account of man-woman relations in domesticity from the neolithic to the " neocosmic ", and much skilful counter argument.

" Man should learn to wield the broom " was the motion proposed for debate by Prof. Haslewood, who sat in " the chair ", and which was defeated, no doubt due to the brilliance of the Guy's speakers (M. Simpson and T. Treasure), who ably defended the male sex from the intricate webs of feminine argument with which they were confronted. So ably did they carry out their task that they carried the day in spite of there being a female majority, consisting of visitors, nurses and physics, in the floor. This same floor, as opposed to that domestic one which the motion could have had men sweeping, responded with several lively speeches gleefully substantiated by quotations.

It is a change to find a society which actually functions in the students' club and is not lulled to a dusty non-existence in the soporific atmosphere of the anatomy or physiology theatres. I left, coffeed and well entertained, and again mentally congratulating the society on its revival of activity.

D. MORTON.

CORRESPONDENCE

WHAT NEXT?

SIR,—In the Passim of your last edition, reference was made to the apparently increasing apathy amongst students at Guy's. The most unfortunate aspect of that editorial was its very truthfulness.

This was demonstrated the day after publication—Sports Day. Anyone who has ever attempted to organise such a function will, I'm sure, appreciate the amount of work involved.

Mr. Turner, the Sports Day organiser, must have derived little satisfaction from the fact that a mere hundred and fifty people came to Honor Oak Park on that sunny afternoon. Sixty of these were children.

If the response from the hospital community, which must contain at least two thousand people under the age of twenty-five, is to be as poor as this, then the worth of Sports Day and the organisation required must be seriously questioned.

The response from members of the Hospital staff and their families was better than has been the case on Sports Day for a number of years. The same cannot, I regret, be said of the students. A number of the athletic events contained two or three competitors—mostly members of the athletic team! Surely untapped athletic ability must exist in a student body of this size.

The value of participation in such events enabled the Hospital to win both the University and United Hospitals' Championships this year. Anyone who is prepared to " have a go " is ensured of success if his fellows are not prepared to do even that, and these championships proved just that.

Very few " had a go " at Honor Oak Park. Your editorial implied that sporting interest crippled the non-sporting clubs at Guy's. There is little danger of this at present, since it would appear that very few people are particularly interested in either of these worthwhile types of extra curricular activity.

Yours, etc.,

16th July,
East Wing,
Guy's.

D. A. G. BARFORD.

Just in Passim

SIR,—I am relieved to hear that James Saunders was not guilty of the first half of Passim in the issue of May 28th. Over the years, one has become used to finding in Passim writing that varies widely in quality (and we use that word in its *loosest* sense). The style has varied from purple prose to what, judging from some recent efforts, will be chromium-plated P.V.C. prose. For some months now, we have been reading some excellent Passims, such as " The Not So Super Structure", on February 19th; and indeed " Quoth Gibbon?" in your last edition. Seldom, if ever, before have we had such scrappy, frenetic, Kandy-Kolored, Tongue-in-Chic writing as in " Passim on Passim." "Are we heard?" asks one of the Passimists. The answer, if such writing is tolerated, must be—very seldom.

Yours, etc.,

A " SMALL, LARGELY EXPATRIOT " READER.

Seldom before have we printed so Tongue-in-chic a phrase as Tongue-in-chic. [EDS.]

REVIEWS

" WHAT FREUD REALLY SAID."

By David Stafford-Clark. Macdonald. London.

Every generation produces its outstanding personalities, and those of the first half of this century have proved no exception. One such product was Sigmund Freud. Brilliant, controversial, universally known but not equally accepted, this man was for over forty years in the forefront of psychological thought. Over nearly half a century he was a prodigious writer, expounding, in one paper after another, each further step in his theory of psychoanalysis. He was always a great writer with a flair for logical exposition so necessary in such a theoretical subject. To read him should be the aim and pleasure of many outside psychiatry, and Dr. Stafford-Clark has done a service, in presenting for the first time, a critical and lucid formulation of psychoanalytical theory and practice. We are taken on a journey through all the famous writings of Freud, starting with his studies on hysteria, the interpretation of dreams, the psychopathology of everyday life, on to his general theory of the neuroses right up to his final and most controversial writings on " Beyond the Pleasure Principle."

Many readers untutored in the jargon of psychoanalysis, may prematurely abandon these great works, but should they have the good fortune first to read Dr. Stafford-Clark, this will most certainly not occur. From this book the reader will grasp the essence of Freud's theories and, with the help of the glossary of terms, will develop an insight into Freudian vocabulary so that he will develop a desire to read the original papers.

This book should be studied by all students of medicine and psychology and enjoyed by those already versed in psychoanalysis.

A.J.O.

COMPANION TO " ILLUSTRATED PHYSIOLOGY."

Ann B. McNaught. E. & S. Livingstone Ltd., Edinburgh, 1965, p. 256. *Price* 12*s.* 6*d.*

This handbook is designed to complement Illustrated Synopses of Physiology which the author has already published. Hence the title, which is misleading. No doubt this book is a very useful companion to " Illustrated Physiology", but what the title does not make clear is that it can stand on its own without the picture books. In fact, a considerable amount of physiological fact is contained in this pocket size book, and it should be most useful to nurses and physiotherapists. The production is up to the publisher's usual high standard, and at its price is very good value for money.

I. MACDONALD.

GERIATRIC CARE

BY

Dr. A. J. ROSIN

Geriatric care means the provision of help for disabled or potentially disabled old people. The main types of such help come from four sources:—

(a) The family contribution.

(b) Social support from the community.

(c) Special residential arrangements.

(d) Medical care.

THE FAMILY.

The family is the stable unit of our social order. If the Welfare State assumes some responsibility for the care of old people, it only does so to supplement family care, or to replace it when the latter has broken down. Strong family ties are the best insurance of adequate care in old age. They have been shown to exercise the strongest influence in counteracting loneliness or desolation. The absence of relatives because of death, distance or disinclination produces circumstances which render an old person at risk to isolation, depression, neglect and self-effacement.

The factors determining whether an old person lives with relatives are complex. When an elderly parent lives with a child, it is more often with a daughter than a son. This is usually caused by the early death of the husband, or birth of the child when the parent is middle-aged, or avoidance of marriage by the child. The responsibility settles more often on a younger child, and it is uncommon for a parent to live with several children in turn. The classic failure of this scheme was well illustrated in Shakespeare's "King Lear".

An important aspect of successful family living is reciprocation. The parent or grand-parent contributes to the household by doing small chores, errands, cooking, baby-sitting, etc. His or her place of honour is thus assured, as is the more intensive care required by him if illness occurs later in life.

Many old people appear to live alone. This does not necessarily mean that they are neglected by their families. It is often by choice that a widowed spouse maintains himself or herself alone in the old family home. What they require from their families is a continued interest in the form of visits; support when needed, particularly with chores that they are unable to do, such as decorating, cleaning or even

shopping or cooking; and above all, understanding and respect. Thus the term "living alone" must be qualified by the amount of regular help that the old person receives from the immediate and less immediate family. For example, a grandmother living with daughter and family, and ignored or merely tolerated can feel more lonesome than an individual of the same family status who lives by herself and is able to regulate her own daily routine.

The roots of successful family support for an old person are laid many years before the pension arrives. A mutual affection of long-standing between parent and child often allows great physical nursing difficulties to be overcome which are encountered in the course of chronic illness. On the other hand, emotional indifference on the part either of the parent or the child, which has become established from younger years will produce a nauseous objection to even minor helping procedures such as the emptying of a parent's bed-pan. A daughter gave up her job to look after her demented mother—"because she's our Mum and we love her. She's been a good Mum to us, and this is how we pay it back". At the other extreme one meets the individual who is only too ready for the spouse or parent to be cared for permanently in hospital when the background has been a stormy marriage or a broken home. When they are tested by the frailty and illness of old age, the strain may be too great, and the family support fails.

SOCIAL SUPPORT FROM THE COMMUNITY.

The development of social legislation for the aged has been designed to help those who have no further personal ability to maintain themselves, and to assist families in which a strain is imposed by the presence of a disabled old person.

For basic material subsistence men over the age of 65 and women over the age of 60 may claim the old age pension of £4 16s. 0d. for a single person and £6 10s. 0d. for a married couple. This can be supplemented by grants from the National Assistance Board for essential basic payments such as rent, extra food, extra heating devices, gas cookers and health appliances.

The Local Authority provides community supervision by means of Welfare Visitors, but difficulty is sometimes experienced in their finding out the cases most at risk, that is, the isolated old people. Some Boroughs, such as Southwark, have adopted the idea of a Register of disability of old people, and their referrals come from General Practitioners, voluntary organisations, the Church, and hospital Medical Social Workers. The Welfare Visitor who is sometimes a trained social worker or works under the guidance of one, makes contact with the family, listens to their problems and tries to arrange appropriate help. This includes such home aids as a commode (obtained from the Red Cross Organisation), or a hospital type of bed, or an overhead pulley to the bed, or the fixing of rails in the toilet, etc. The organisation of a holiday for the old person, or regular trips to a day centre, are also undertaken by Welfare Officers.

For the fitter, retired person who is able to get out and about or who has a variable degree of handicap, some Boroughs have organised part-time sheltered employment. These Sheltered Workshops provide simple repetitive tasks often by contract to outside firms, and the work is arranged during two or four-hourly sessions daily. Some local authority day centres have occupational therapy departments and many have transport available for house-bound old people who can look forward to some regular activity once or twice a week. By these means, some of the boredom and despair of the retired person in old age is alleviated.

The Public Health Department of a Borough generally includes the Home-Helps organisation. Successful home helps do more than clean the house or fetch shopping or cook lunches. They often become a stable pivot of an old person's life. They may be the only regular visitor to one who is bereft of relatives. The constancy of their appearance helps to maintain the rhythm of a lonely old person's life as well as assist with basic domestic needs.

Another useful form of home supervision has been the **Good neighbour scheme.** Many old people or their relatives arrange this themselves, but in a few Boroughs it has been brought under the auspices of the Public Health Department. A central organiser arranges for a suitable friend or acquaintance to be paid a small sum weekly in return for regular daily visits to keep company and assist in simple personal tasks such as dressing or offering a helping hand. This is neither nursing nor is it purely a domestic function. It does serve to prevent isolation, promote interest and detect progressive illness.

District nurses have a large scope in the community care of old people. They attend to dressings, injections and general care, including washing. They also have the opportunity to carry out simple rehabilitative measures such as are performed in geriatric wards, e.g., standing and walking practice, limb movements and muscle strengthening exercises. Some Boroughs also provide night sitters to supervise terminal illness in the home, often as a help to the relatives.

The problem old people face of feeding themselves may be accentuated by confinement to the house and disinclination to cook. These features were found to be present particularly in the over-75 year age-group. Meals-on-wheels services organised by the W.V.S. and usually taken over by the Borough Council, form a useful support, sometimes the only support, to the nutrition of old people. Invalid meal services and special diets, e.g., for diabetics, can also be arranged in some places.

The part played by **voluntary organisations** in helping old people at home is of great importance. Many Boroughs have an Old People's Welfare Committee, which as a voluntary group is subsidised by the Council. They run old people's clubs, luncheon clubs, day centres and often have paid or voluntary workers deputed to visit a number of elderly people at home. The Committee serves as a co-ordinating group in the community for any body interested in the welfare of the aged. Other voluntary groups include visitors for special types of

disability, e.g., Societies for the Blind. Much good work in the form of practical help is done by Church and other religious groups, Youth clubs and Scouts and similar movements. This kind of aid and social contact varies with the locality and with the enterprise of the organisers.

SPECIAL RESIDENTIAL ARRANGEMENTS.

At the stage when it is no longer desirable for an old person to remain in his own home, several alternatives are available. In the past ten years or more, increasing numbers of Local Authorities have been building or converting houses to self-contained flatlets for old people. A caretaker is appointed to one house or one group of flatlets. The old person thus has his own home and furniture but a helping hand is available when needed. The resident may ask for any of the domiciliary services described in the previous section. A local example of this is the Abbeyfield Society which, under the initial direction of Major Carr-Gomm, bought some houses in Bermondsey, each of which now houses four to six old people, with a resident caretaker.

One of the lounges in the Southwark Park Road Home, for 50 people, opened in 1965. Built and maintained by the London Homes for The Elderly, a voluntary organisation, the amenities provide spacious rooms and a friendly atmosphere. This is a home and not an institution.

The Welfare Department of the local authority has the statutory function of providing residential accommodation for the elderly and disabled, who require care and attention. During the period before the Second World War, most of this consisted of large institutions with several hundreds of beds in each. Many of them are the original workhouses of the 19th century, in which life has a variable lack of privacy. Though modernisation has improved the amenities in some of the large Homes, the trend is to replace the Institutions with smaller Homes, usually housing between 30-60 residents. A full description of social investigation of these and other residential Homes is well documented in Peter Townsend's revealing book, "The Last Refuge". Many of the smaller Homes have pleasant surroundings. The residents are required to be able to manage basic activities of daily living—toilet needs, dressing, feeding, etc. The Home usually has a trained Matron and lay staff. Some are specially adapted for disability, e.g., Homes for blind persons, extra staffing in Homes for frail, aged people and a few Homes for ambulant demented old people.

Another scheme provides supervised accommodation for physically or even mentally disabled old people in ordinary households. The local Council arranges that the landlady receives a grant, usually from the National Assistance Board, to help her with the day-to-day care of the "lodger". This boarding-out project is still in the experimental stage. It requires careful selection of both landlady and potential lodger.

MEDICAL CARE.

The significant break-through in the last 30 years for medical care of old people has been the establishment of specialised geriatric units in hospital. An active policy of rehabilitation has been pursued and many old people are able to be discharged from hospital who previously would have been thought to need permanent hospital care. The pattern of medical care is made to fit the patient's needs. These units cater for the longer period of convalesence required in old age, and assessment and planning of the patient's social needs receive due emphasis. In some geriatric departments, patients are moved from the ward with more intensive medical care when the acute phase of the illness is past to one where the accent is on acquiring independence and self-care. Each department also contains a large proportion of long-stay patients. The emphasis in the long-stay wards tends to be on social and diversional activities in addition to the nursing care which the patients require.

The geriatric hospital supplies other services which differ from those of general wards. For example, holiday admission of old people allows relatives to have a pre-arranged break. In some cases, the intermittent admission to hospital of a chronically disabled old person establishes a useful partnership between the geriatric staff and the family. The latter may find that the care and management of

their relative is no longer an oppressing burden without relief or end. The geriatric day hospital supplies a need to those patients who need treatment or supervision during the day, but who can be looked after at night in their own homes.

The General Practitioner is a key figure in assessing the needs of disabled old people. With his knowledge of the family background and the home circumstances, he has a great opportunity of practising preventive medicine, and of detecting undernutrition, early signs of disease, neglect and dementia.

The medical aspects of geriatric care cannot be divorced from the services provided by other members of the community. The doctor is part of a team which includes social workers, welfare officers, nurses, home helps, voluntary workers and many ordinary people.

CONCLUSION

This article has presented the main types of geriatric care from the viewpoint of the ageing person. He turns first to the family, but the community also undertakes a large degree of background support. The Table summarises some of these services under the appropriate headings. The answer to a geriatric problem is often not satisfactory because the nature of old age does not permit a satisfactory solution. But the mark of an advancing society is surely to try and convert the passivity of senile decline into an active, happy old age.

GERIATRIC SERVICES

GOVERNMENT	LOCAL AUTHORITY			VOLUNTARY
	Housing	**Welfare**	**Public Health**	
Pensions	(Including special housing—old people's flatlets)	Residential (Part III) accommodation	District nurses	Old people's welfare Committee
National Assistance			Home helps	
National Health Service		Welfare visitors and Social workers	Health visitors	Voluntary visitors
General practitioners			Meals-on-wheels	Old people's clubs
Hospitals		Welfare for the handicapped	Clinics—e.g., Chiropody, old people's health clinics.	Residential Homes.
Geriatric departments		Incontinent laundry service		
Day hospitals		Day centres		
		Old people's clubs		
		Lunch clubs		
		Holiday schemes.		

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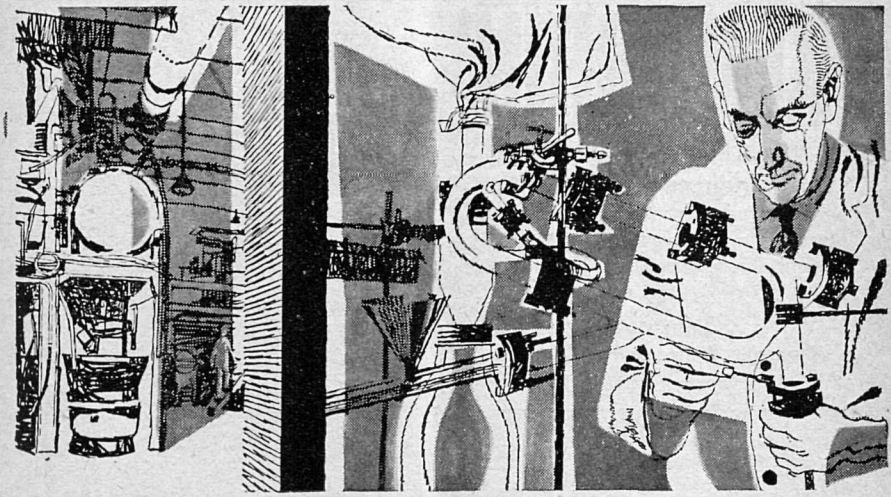

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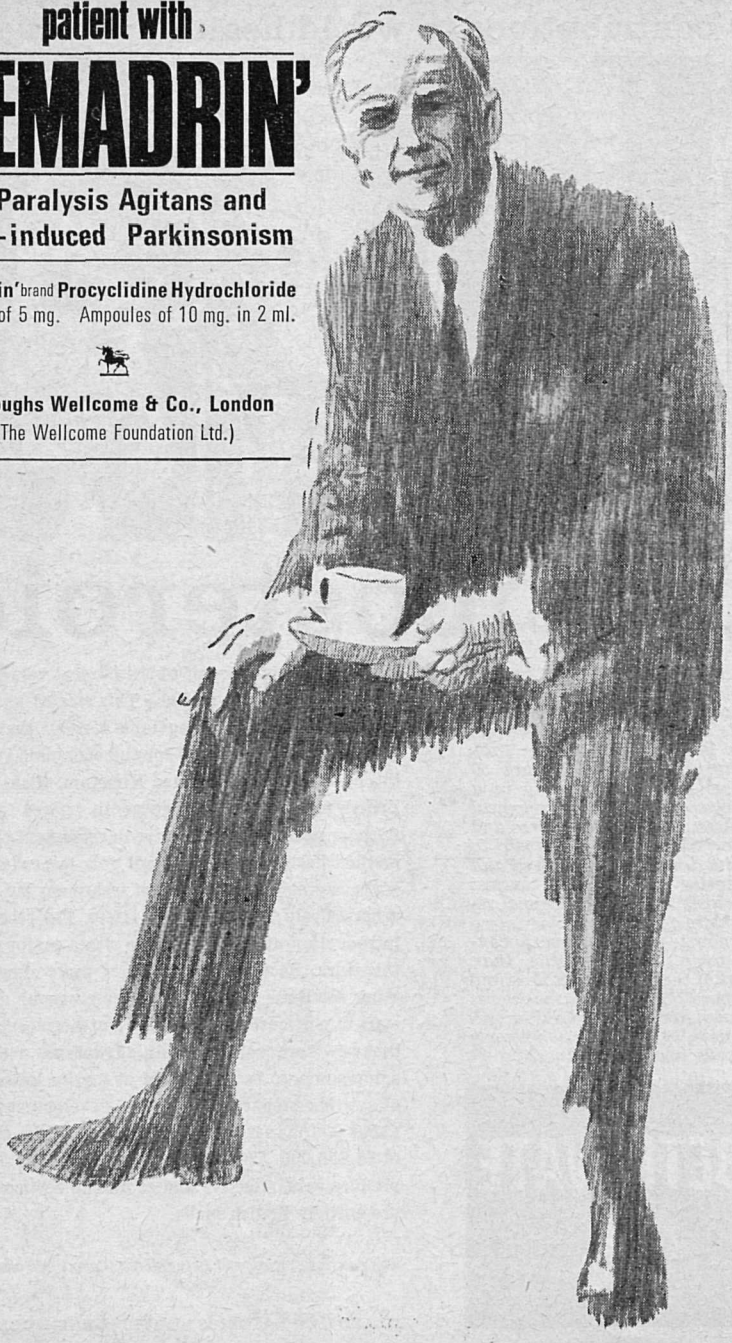


NURSING SECTION

FROM P.T.S. TO INTRODUCTORY COURSE

In June of last year the P.T.S. (Introductory Course since October, 1965), returned to Guy's from Holmesdale. As a result of the move there have been many changes in the life of an Introductory Course Nurse. The rather tedious bus journey to work in the wards on Mondays is no longer necessary. Instead, with an intake of 75, 5 groups of 15, each day from Monday to Friday, one group spends a number of hours in the wards. Pre-Holmesdale nurses will say, " We were doing that 20 years ago", but there is a difference.

Seven members of the teaching staff, each taking two or three nurses, work with them in the wards. The time is spent in bathing patients, making beds, helping to serve meals and in performing simple treatments. The course lasts eight weeks. In the fifth week each nurse is allocated to her own ward, where she will also work on completing the course. She works the various shifts in turn, including one night on duty. One member of the teaching staff is on night duty for five nights and visits each of the 15 nurses several times during the night.

Classroom teaching takes place in relation to ward experience. Adequate preparation is arranged before any ward procedure. At the bedside, therefore, the procedure is not unduly prolonged by explanation. This is a most important point, particularly where there is a large number of student nurses. Although teaching in the ward is ideal, it could be tiring for the patients.

But life is not all work. The nurses soon fit into the pattern of life in the home, blocking the corridors and holding up the lunch queue for only the first few days. After the first conducted tour of the hospital, in small groups, they find their own way round, getting lost in the underground, but arriving in the theatre domes within the first week. They are prepared to join in everything, leaving little time for study in the evenings.

The nursing staff are more aware of their most junior colleagues and take a kindly interest in them. Since the introduction of the mauve band on their caps, they are more easily identified. However, being in larger sets and in the larger community, they find it more difficult to get to know each other. At Holmesdale it was easy to get to know one's colleagues very well when there was an hour's domestic work each day, washing up and potato peeling demanding little concentration. Holmesdale was fun, with its welcoming lights at the end of a dark drive, the daffodils and tea on the lawns at week-ends. We are glad to have been there, but it's nice to be back and are grateful to everyone who has helped us settle in so happily.

SISTER THIRZA.

[Extract from a letter to Miss MacManus by Miss Ruth Jacobs, of Burton Bradstock, Dorset.]

" You were probably at Guy's Hospital when my grandfather was there—in Samaritan Ward. He was very interested in Guy's because his little boy was in there in 1870, before he died. My grandfather used to take his carrier pigeon to the hospital and the Matron (? Sister) used to see him in the corridor, when she used to put a message on the pigeon, which then flew home to Erith in Kent, where my grandmother awaited the message to know how Tommy was."

STAFF CHANGES AND APPOINTMENTS

DEPARTURES

Sister V. M. Taplin from Mary Ward.
Sister E. A. Williamson from night duty on Caleb and Diplock Wards.
S/N E. Dietrich from Casualty.
S/N M. Graham from Main Theatres.
S/N S. E. Griffiths from Out-patients.
S/N N. Hallam from Main Theatres.
S/N C. Hanratty from Out-patients.
S/N N. N. Kearney from Main Theatres.
S/N J. Reckett from night duty on Stephen Ward.

APPOINTMENTS

Sister J. S. Penlerick, trained at the Bolingbroke Hospital, to Samaritan Ward.
Sister D. M. Roxburgh, trained at the Glasgow Royal Infirmary, to Main Theatres.

SPORT

Guy's hopes of having a clean sweep in the Summer United Hospital Competitions suffered a rude shock in the last fortnight with both the first and second XI's knocked out by the equivalent St. Thomas's side in the semi-final of the cricket cup. The 1st XI lost by 5 wickets in a replay on June 13th, having drawn the previous Thursday. In the replay the team were below strength, but nevertheless to be dismissed for 105, after an opening stand of nearly 50, is a rather poor performance, particularly as Guy's had finished at 209 for 4 when chasing a score of 279 only the Thursday before.

The 2nd XI fared little better on June 15th at H.O.P. St. Thomas's won the toss and decided to bat on a greenish looking wicket, and by the time their 40 overs were up, had scored 171 for 9. This score was aided by some rather loose bowling to begin with and some unreliable fielding and backing up. At least twelve runs were given away in overthrows. When Guy's batted, requiring little more than four an over, their batsmen were as unreliable as the performers in the field, and, although Guy's kept up with the clock, wickets fell at regular intervals, so that Guy's were all out for 127 with eight overs to go. Throughout the season the calling and running between wickets has been really atrocious, resulting in several run-outs, three against St. Thomas's. The total for the season is now 17.

In club matches the 1st XI have had better success, particularly with a fine win in the Past v. Present match last Saturday. The Present batted first and scored 230 for 4 declared, with Butchey scoring 70. The Past were dismissed for 114.

Sports Day on June 11th was as usual organised very well, but suffered by there being very few competitors for the Athletic events. Even more distressing was the very poor turnout of students as spectators. The enthusiasm at present for supporting sporting events is pathetic. This present apathy spreads throughout the hospital for all meetings, etc., and it is well nigh tragic that more students, whether medical or dental, and more nurses do not attend such occasions. Surely it is not too much to ask of a student to attend H.O.P. for a couple of hours on a Saturday afternoon, whether it is to watch the 1st XV, the soccer or hockey teams, or on Sports Day. I wonder if a census were taken of the people training at Guy's at present how many were found never to have been to H.O.P.!

The 1st Tennis VI had a bye in the first round of the U.H. Cup, and beat the Royal Free 7—1 in the second round.

The Cricket Club's match with the Nurses has been fixed for July 23rd on the Crofton Park ground, beginning at 2.30 p.m.

Finally we must wish the best of luck to the members of the Golf Club taking part in the British Universities' Championships in Llandudno from July 4th to 8th.

DIARY

CRICKET.
June: Sat, 25th—Mote, 11.30 a.m. Away.
Sun., 26th—Addiscombe, 11.30 a.m. Away.
Wed., 29th—Queen's Belfast, 2.30 p.m. Home.
July: Sat., 2nd—U.C.S. Old Boys, 2.30 p.m. Home.
Sun., 3rd—Mayfair, 2.30 p.m. Home.

TENNIS.
June: Sun., 26th—Tunbridge Wells. Home.
July: Sun., 3rd—Final, Guy's Competition.
Wed., 6th—U.H. Final.
Thursday, 7th—R.N.C., Greenwich. Home.

LADIES' TENNIS.
June: Sat., 25th—St. Bartholomew's Hospital. Home.
Wed., 29th—Westminster Hospital. Home.

GOLF.
July 4th to 8th—British Universities' Championships, Llandudno.

CRICKET

GUY'S v. TEDDINGTON

Away — Saturday, 4th June, 1966

Result: Guy's won by 7 wickets

Teddington: 167 for 9 dec. (Clark, 3 for 13.)

Guy's: 171 for 3. (Clarke, 42 n.o.; Appleby, 41 n.o.; Chase, 34.)

The team went along to Teddington, not only eager to avenge the ignominious defeat of last season, but also anxious to create a good impression in other respects—not with the ultraistic and noble motive of gaining a good name for the hospital abroad, but in order that two at least of the team might attain places in the Teddington side again this year after the Guy's fixture list terminates.

To the surprise of the opponents—and indeed the Guy's team itself—the first ball was bowled very shortly after 2.30. Today, alas, the opening bowler's length and direction were not quite as immaculate as the crease in his flannels! Nevertheless, he soon induced Dandridge, who had started briskly and confidently, to sky the ball in the direction of the mid-off boundary; fortunately a strong breeze in the stratosphere enabled Crafts to make a good running catch to dismiss the Teddington skipper. For the next hour tight bowling by Clarke and resulting mediocre batting had wickets tumbling steadily, and it was not until Crafts jnr. joined Mathews that Teddington began to amass a respectable total. Declaration on the dot of five at 167 for 9 spared the Guy's fielders from breaking any more thumbs in their brave—but usually unsuccessful—attempts to catch the ball.

For once a few superlatives would not be amiss in describing the Guy's innings. It was —as the "Evening News" would have put it— "sparkling"—Joseph "Sunshine" Butchey, in a motley collection of borrowed kit, and Chase opened the innings watchfully against Crafts jnr.—an accurate "trundler" destined for Guy's next year, exam results permitting, and Carmichael, a rapid though wild fast bowler who has represented Middlesex 2nd XI. However, when Appleby joined Clark—the Somerset man—the pace accelerated to such an extent that there never seemed to be any doubt the target would be reached. The latter particularly was in his most elegant form, and in contrast Appleby employed his inside edge surprisingly little and hit lustily with the middle of his shoulderless and strapless bat.

And so, with five minutes to spare, a convincing and deserved victory was recorded, and Guy's prestige at Teddington was not only restored but raised sky high by such fine batting, which, remarked a delighted spectator, was "how they used to bat in the old days!"

J. K. CRAFTS

GUY'S v. HAMPSTEAD

At H.O.P. — Sunday, 5th June, 1966

Result: won by 15 runs

Guy's: 147. (Gillham, 51.)

Hampstead: 132. (Steer, 5 for 44; Clark, 3 for 38.)

Guy's won the toss and elected to bat on a green-looking wicket. Hampstead took the field with only one member of last year's defeated side and a battery of seam bowlers. Butchey and Gillham opened quietly against some good, accurate bowling, and it was not until Stewart was brought on as first change that wickets began to fall. Gillham continued to bat soundly and reached a very creditable 50. Griffiths and Swift were the only others to put up much resistance, and the innings closed at 147.

To win, tight bowling and keen fielding would be needed; in actual fact, all four bowlers used gave little away, and the fielding was a distinct improvement on recent performances. As a result, Hampstead had to fight hard for their runs, and a win for Guy's always seemed likely. A dangerous looking seventh wicket stand of 30 was finally broken by Steer, and the last two wickets fell rapidly. Steer finished with 5 for 44 off 21 overs. Thus Guy's gained a deserved victory over one of our strongest opponents.

M. APPLEBY

GUY'S v. ST. THOMAS'S HOSPITAL

At Cobham — Thursday, 9th June, 1966

Result: match drawn

St. Thomas's: 279 for 6 dec. (M. Smith, 81; M. Read, 53 n.o.; M. Hutson, 40.)

Guy's: 209 for 4. (Butchey, 106 n.o.)

If ever there was a toss to win, then this was it. A perfect batting wicket, a fast outfield, and the temperatures in the low eighties made the prospect of fielding rather unattractive. Yet Guy's were destined to take the field. The first hour bore out the promise of the wicket as the St. Thomas's openers dealt comfortably with all that was offered to them. The score mounted steadily on through the fifties and sixties to 74 before Hutson was well caught at leg slip off Clark. Only one further wicket was to fall before lunch when the total reached 142 for 2. Throughout the morning the bowling had been fairly tight, but it was primarily the excellent fielding by every member of the side that kept the score to within reasonable limits.

Davoodbhoy captured a quick wicket after lunch which was a valuable morale lifter. Another dismissal then might have turned the tables. However, it was not to be. As the afternoon progressed and the sun relentlessly bore down sapping energy and concentration, real chances were made into only half chances, and half chances went begging. Davoodbhoy bowled unchanged and uncomplainingly for 43 consecutive overs and was still able to touch his toes at the end, unlike his colleague, Butchey, who couldn't, even before he bowled his seven. Despite this great bowling feat and the all-round fielding display, St. Thomas's were able to amass 279 before they declared at six wickets down. They had scored at a rate of three runs per over.

Guy's were thus set this target in much the same time as that taken by their opponents. Time considered alone is apt to be deceptive, the important and only valid consideration is the number of balls bowled. There was 50 minutes batting before tea, a critical period, and both openers did as they were asked, not worrying about the runs but concentrating upon remaining at the wicket. This provided a respite for the rest of the team to rehydrate and collect themselves. Unfortunately, Gillham was soon out after the interval, but he had done his job well. Runs during the next hour just did not come quickly enough despite every effort by the batsmen. Butchey characteristically batted with splendid application and determination and it was just reward that he reached his century shortly before the close. All who witnessed his innings were delighted that he remained undefeated to the end, and was able to maintain his dignity and composure in the force of petty provocations.

When stumps were drawn Guy's had scored 209 runs for the loss of four wickets, at a rate of three runs per over. St. Thomas's had bowled 22 overs fewer than Guy's over the same time period. If the Guy's scoring rate had been unduly slow, which it hadn't by comparison, this still would not have excused the behaviour of a minority of the St. Thomas's

players towards the end. They later regretted their actions and apologised. Such behaviour was neverthless unnecessary and caused considerable embarrassment to the umpires and spectators. It was a pleasure to be associated with a team whose conduct on the field of play has been, and I hope will continue to be, beyond reproach.

J. POWELL-JACKSON

Semi-final replay
GUY'S v. ST. THOMAS'S

At Cobham. Monday, 13th June, 1966
Guy's: 104. (Butchey, 37.) (Kirk Smith, 7—42.)
St. Thomas's: 108 for 5. (Moss, 45; Smith, 30.)

The first thing we noticed when we arrived at Cobham on a fine but cool Monday morning was that the wicket did not look nearly as perfect as it had the Thursday before. It was therefore not very surprising that having lost the toss we were asked to bat.

We were unable to field our strongest batting side; Powell-Jackson and Chase were unavailable and Silk was sunning himself in Majorca —an enforced rest as a result of a broken thumb.

The wicket, as expected, was giving a lot of help to the fast bowlers and at lunch we were 85 for 8. Butchey, who had scored a century in the previous game, was again the mainstay of the batting. His colleagues seemed to have an unhappy knack of playing indiscreet shots and thus getting themselves out, as in fact he did when it seemed he was set for another ton. Appleby and Davoodbhoy were the only ones who put up any resistance. Davoodbhoy, captain for the day, played the bowling well, hitting the ball as only he can and showing the "batsmen" how to do it. Thomas's bowling was steady and was conspicuous for its lack of under-arm bowling. Kirk-Smith got a lot of movement from the wicket and his analysis of 7 for 42 was a good reflection of his performance.

Guy's went on to the field determined to prove to Thomas's that the result of their poor wicket was going to be their downfall. This in fact was not the case and they batted well getting the required runs with five wickets down. Guy's did in fact achieve an initial breakthrough when Beacham bowled the opening bat, but Smith and Moss gradually got on top of the bowling with runs coming fairly easily towards the end assisted by some rather odd fielding by the opening bowlers at squareleg.

Thomas's on the day were stronger in all departments and deserved to win. We wish them luck in the final.

RICHARD BEACHAM

PAST v. PRESENT

Saturday, 18th June, 1966
Result: Present won by 124 runs
Guy's (Present): 238 for 4 dec. (J. Butchey, 70; R. Clarke, 42; P. Griffiths, 33; A. Gillham, 30.)
Guy's (Past): 114. (M. Jones, 34.)

On a very pleasant and sunny day, the Present elected to face up to the wiles of their historic Past, with the memory of last year's glorious victory for the Past still lingering in the minds of all playing.

J. Butchey and A. Gillham started off the Present's innings with a few unorthodox strokes at first, but they later settled down to scoring at just over a run-a-minute. Much to the dismay of the Past, lunch was taken with the scoreboard reading 89 for 0. Lunch seemed to have restored the hypoglycaemic state of the Past to normal and with the third delivery after lunch the post-prandial sleepiness of the Present was disturbed by the sound of Gillham's stumps—alas, the memory of so much potato left untouched was too worrying. Butchey continued the attack but with his score at 70, he was run out from a brilliant piece of fielding by Munro at midwicket. Clarke (42) and Griffiths (33) continued the onslaught, but the former was beautifully caught off a hookshot and the latter was stumped off a ball which ricocheted from MacGregor's pads onto the stumps. Following some brisk hitting by Powell-Jackson and Appleby, Guy's declared at 238 for 4, leaving the Past with more than halftime to get the runs.

Disaster struck ominously when the Past went into bat. With Beacham's fourth delivery, Myall's bails were sent flying with a ball which surprised the bowler much more than it did the batsman. The Past unfortunately never recovered from this early setback and Norman, MacGregor and Hambleton were soon back in the pavilion. Messrs. Jones (34), Munro and Glover tried to hit their side out of danger and even the "bowling" of a very senior member of the Present did not help the score of the Past very much. Barry Ross partnered M. Walters for the last wicket and after Ross had wielded his willow a few times with remarkable luck, Mike Walters was ignominiously run out with the score at 114.

Thus, the Present had duly avenged their defeat of last year. An enjoyable day's cricket was only surpassed in entertainment by free flowing "beverages" at the bar afterwards.

J. R. K. BUTCHEY

ATHLETICS

UNITED HOSPITALS' CHAMPIONSHIPS
Venue: Motspur Park
Result:
1st, Guy's, 90 pts.; 2nd, St. Mary's, 76 pts.

The United Hospitals' Annual Athletic Championships were held on June 1st and June 4th. Guy's were all out to defend their title as champions for the past two years. Following our victory in the University Championships earlier this season the match, according to members of other teams, was a mere formality. However, there was no undue confidence amongst members of the Guy's team and as far as we were concerned it was going to be a hard fight.

On heats day results were not impressive as far as individual performances were concerned; however, we managed to have qualifying members in practically every event. The weather for the finals on June 4th was almost too hot for athletics, the assistance was disappointing on this fine summer day. We had the support of some of our vice-presidents and thank them for their interest in the club. Mr. Tomkinson, our president, took an active part in the field and was our usual entry for the consultant's walk.

The best performers of the day were G. Edwards in the field events, in spite of some technical difficulties (he arrived without his kit), and D. Barford in the track events. Edwards secured the greatest number of points for the club with wins in the Hammer and Pole Vault and third in the Javelin and Discus. Barford had a powerful win in the 220 yds. and came a good second in the 440 yds. D. Osbourne also distinguished himself by winning the Discus with a throw of 138 feet.; he also managed a 5th in the Shot, which was won by Allen Ross of Guy's. Generally speaking Guy's did not look very impressive as there were fewer victories than last year; however, many points were gathered by placings in most events. This again stresses the value of a large team of moderate performers as opposed to a team of a few exceptional athletes. The results in the middle distance events and Mile Medley relay once again showed the team's lack of an ade-

quate number of athletes capable of running the longer races.

At the end of the afternoon spectators were probably rather surprised by Guy's outright win by some 14 points, but looking back at the result sheet this was a very decisive win which ought to be repeated next year. St. Mary's were runners-up in the championship and represent a potential danger for the next season. Guy's win was the third in succession and the 26th victory in the U.H. Championships.

Results:
100 yds.—P. Bundred, 5th.
220 yds.—D. Barford, 1st, 22.5 secs.; P. Bundred, 5th.
440 yds.—D. Barford, 2nd, 51.3 secs.
880 yds.—D. Choat, 5th.
1 Mile and 3 Miles—No placings.
1¼ Mile Steeplechase—R. Wilson, 5th.
120 yds. Hurdles—J. Domaingue, 2nd, 16.7; M. Bates, 5th.
440 yds. Hurdles—G. Edwards, 5th.
High Jump—J. Domaingue, 3rd.
Long Jump—J. Domaingue, 4th; M. Bates, 5th.
Triple Jump—M. Bates, 2nd; J. Domaingue, 4th.
Pole Vault—G. Edwards, 1st; P. Bundred, 2nd.
Shot—A. Ross, 1st, 44ft. 10ins.; D. Osborne, 5th.
Discus—D. Osborne, 1st, 138ft.; G. Edwards, 3rd.
Hammer—G. Edwards, 1st, 122ft.
Javelin—B. Hartley, 2nd, 178ft.; G. Edwards, 3rd.
There was no tug-of-war this year.

SPORTS DAY

Sports Day was held this year on the 11th of June. The weather, which had been glorious on Heats day, the preceding Wednesday, was in our favour although it was rather cloudy later during the day. A thunderstorm during the course of Friday night added to the burden of Mr. Chick, the groundsman, who had to mark the track again on Saturday morning. Our thanks go to him for getting the grounds in a suitable condition.

The assistance was scanty. Lack of support on a cold and rainy day, as we have had for the previous two sports days, is excusable but the lack of interest seen this year is rather distressing. A large number of the staff were present and we are very grateful for their support and hope that this will set an example to Guy's students; unless supporting the Guy's athletic team once a year is to the detriment of their academic pursuits

For various reasons several members did not compete and their absence was felt. With A. Winskill, R. Morris, P. Peace and D. Tong amongst others having left this year the number of athletes left to compete in some twenty events was hardly more than a mere score. D. Barford distinguished himself in the track events with a series of good performances and wins in 100 yds., 220 yds., and 440 yds. Probably the best performance of the day was that of A. Ross in the shot with a throw of 45ft. 6ins., breaking the old record by over a foot.
D. Osbourne did well in the Discus and Javelin, winning both events. The jumps and hurdles were more or less a competition between M. Bates and J. Domaingue through lack of other competitors. Both track and field events could have been more interesting had G. Edwards, B. Hartley and I. Morgan been able to compete.

A tug-of-war competition between the nurses, physics and Rugby Club brought some interest with victory for the nurses (a very large team) in a series of pulls against the 1st XV team. The usual sack races, children's races, a ladies' egg-and-spoon race as well as the club's relay gathered a fairly large number of competitors when compared to the more classical athletic events. The traditional beer race was won by the "Old Boys' Rugby". I would be grateful if the winner of the nurses' 100 yds. race could get in touch with me or any other member of the club since her prize is still in our possession.

The club was very proud and honoured by the presence and support of Mrs. Tomkinson who awarded the prizes. Mr. Tomkinson has been one of the keennest supporters and president of the club for a number of years and has again this year given up many hours of his time towards the success of the athletic club. In his speech the president stressed our victories in the University Championships and the United Hospital Championships and pointed out that is was due mainly to the depth of the team and not, to a few individuals. This complete team, with no exceptionally brilliant athlete, was in his opinion the best in athletics that Guy's had ever produced. Lastly, in a few words, the captain, D. Barford, thanked all those who had helped with Sports Day, especially L. Turner and his team, who had the burden of the organisation.

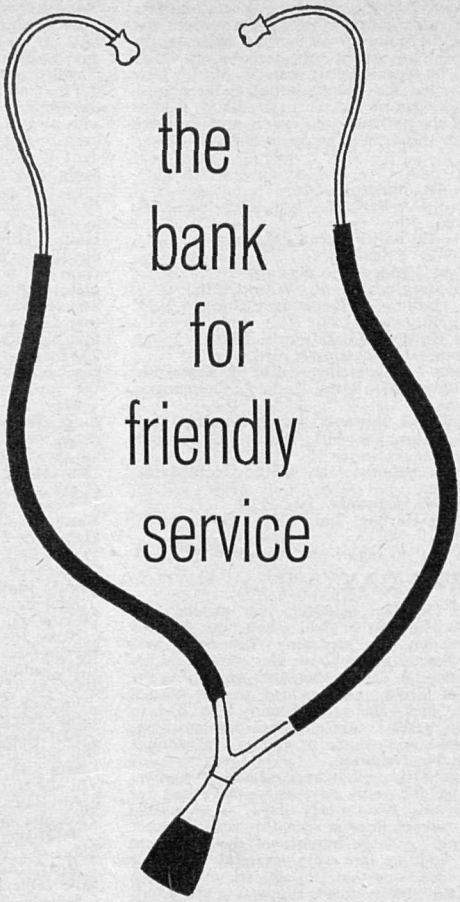
May we take this occasion to thank the judges for their invaluable help, the vice-presidents who have granted us their support, and all those who have helped with the organization and running of the side-shows. We also thank all those who helped us in the evening to run the dance, held in the pavilion.

Results:
Hammer—J. Ross, 1st, 67ft. 8ins.; G. Voss, 2nd, 64ft. 2ins.
2 Miles—B. Smith, 1st, 11 mins. 35 secs.
Triple Jump—M. Bates, 1st, 42ft. 6ins.; J. Domaingue, 2nd, 41ft. 7ins.
Discus—D. Osborne, 1st, 127ft. 3½ins.; J. Ross, 2nd.
Javelin—D. Osborne, 1st, 139ft. 9ins.; T. Higgenbottom, 2nd.
100 yds. (Open)—D. Barford, 1st, 10.4 secs.; G. Vos, 2nd, 10.6 secs.
Long Jump—J. Domaingue, 1st, 20ft. 6ins.; M. Bates, 2nd, 19ft. 7ins.
880 yds. (Open)—D. Choat, 1st, 2 mins. 8.2 secs.; D. Briggs, 2nd, 2 mins. 8.4 secs.
120 yds Hurdles—J. Domaingue, 1st, 17.1 secs:; M. Bates, 2nd, 19.6 secs.
220 yds. (Open)—D. Barford, 1st, 23 secs.; T. Higgenbottom, 23.9 secs.
Shot—A. Ross, 1st 45ft. 6ins. (Record); J. Ross, 2nd, 38ft. 7ins.
Mile (Open)—D. Choat, 1st ; R. Wilson, 2nd.
440 yds. (Open)—D. Barford, 1st, 52.0 secs.; T. Higgenbottom, 2nd.
High Jump—J. Domaingue, 1st, 5ft. 3ins.; M. Bates, 2nd, 4ft. 11ins.
Victor Ludorum—J. Domaingue, 28 points; Runner-up, D. Barford, 25 points.

LAWN TENNIS

Guy's received a bye in the 1st round of the Hospitals' Cup and defeated the Royal Free, who were entering for the first time, in the 2nd round. Despite rumours to the contrary, the Royal Free did not have to include any women in their team and arrived with six men prepared to play tennis. With one exception their team was not as strong as the Guy's side, who had secured a victory by tea and finally won by eight rubbers to one.

This victory and a 7—1 win against the London Hospital the following Saturday suggested that the side were beginning to find their form. However, such illusions were shattered the next week-end when the 1st VI was twice beaten unnecessarily. It was particularly disappointing to lose to Park Langley who had to field a much weaker team than they



National Provincial

The Guy's Hospital Office, which is opened for your especial use, is under the management of Mr. A. C. Edwards, Southwark Branch, 10-14, Southwark Street, London, S.E.1, and enquiries will be welcomed.

wished and were expecting to be beaten. Guy's led 2—1 at the end of the 1st round but from then onwards only Hopkins and Newman succeeded in winning any further rubbers, and the match was lost 5—4. In view of the weakened opposition and the fact that Guy's won the first set in three lost matches this was not a satisfactory result.

At present there is a lack of enthusiasm towards playing in 1st team matches and more so towards the singles competition. Clubs of this sort cannot flourish unless the top players are prepared to make an effort to participate in club events. Without this enthusiasm the club will continue to lose matches and club sides will not be prepared to continue giving Guy's fixtures. Since Guy's has been the only hospital able to maintain a fair standard and an interesting fixture list over the years, it would be unfortunate for the present apathy to continue and ruin the recently strengthened fixture list.

The 2nd VI have been unlucky in having several matches cancelled, but three members of the second team did play in the first mixed match Guy's have played for many years. If a lost match can be called successful then this new venture was a success! The match was greatly enjoyed by both teams and a return fixture is planned for later in the season.

J. H. NEWMAN

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL, S.E.1.

Applications are invited for the post of **Lecturer in the Department of Surgery,** with duties commencing 1st October, 1966, and appointment for one year. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be returned not later than **30th June, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Cardiology,** for a period of one year from 1st October, 1966. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned by **30th June, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Junior Registrar in Ophthalmology,** for a period of one year from 1st October, 1966. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned by **30th June, 1966.**

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy as **Senior Registrar in Physical Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.** Applicants will be expected to spend two years in the region during a four-year tenure of the post. The appointment will be made jointly by the bodies concerned. The post in the Regional Hospitals will be held in the Bromley, Orpington and Sevenoaks Groups. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) with duties commencing 1st October, 1966. Forms of application are obtainable from, and should be lodged with, the Superintendent Guy's Hospital, S.E.1, not later than **30th June, 1966.**

PASS LIST

UNIVERSITY OF LONDON

3rd (M.B., B.S.) Examination for medical degrees. April, 1966

Honours

Carolyn J. Mowbray
(Distinguished in Medicine and in Obstetrics and Gynaecology)

Pass

P. J. C. Baxter	M. E. Pembrey
S. F. Din	P. C. Pietroni
K. N. Dunn	H. E. G. Rees
L. D. Edward	D. J. Rhodes
D. P. Evans	J. M. Richards
H. Gareeboo	Lyall M. Rikard-Bell
T. J. Gibson	I. F. Roberts
T. H. Guerrier	G. F. Rushforth
D. J. Hendrick	P. J. Rushmer
C. W. Howell	J. F. Searle
P. S. Hughes	G. Smith
M. H. Jourdan	R. A. J. Spurrell
M. R. L. Joyce	A. L. Stanhope
Joy S. Lawrence	Clare E. Stannard
D. K. Masters	Isobel M. J. Stephen
P. R. G. Needham	G. A. W. Taylor
C. L. Newman	D. Tong
J. Nicholson	B. H. Valentine
M. W. J. Older	M. S. Vernon
P. K. Peace	P. A. D. Williams

Part 1

W. V. Annan	R. N. Kirby
R. J. Birts	A. J. O'Donnell
J. M. Brummitt	R. J. V. Ramage
W. A. K. Burke	G. E. Ratcliffe
J. R. Gibbs	M. F. Rumpus
J. R. Gill	D. H. Sawyer
J. R. Govan	D. F. H. Wardle
D. A. N. Johnson	Diana J. Whitfield

Part 2

T. S. Brown	S. O'D. McCall
Mary T. Cunningham	C. P. Malpass
J. R. Govan	C. A. C. Pickering
M. F. Hadoke	D. C. Siggers
Helen Hale	W. Snidvongs
D. P. Leiberman	C. J. Watson

Part 3

W. V. Annan	D. B. Mathias
J. R. Gibbs	Theresa D. Pietroni
J. R. Govan	A. E. Raynes
M. F. Hadoke	M. F. Rumpus
D. L. Ingram	D. C. Siggers
R. N. Kirby	R. P. D. Toone
Susan L. Kramer	T. D. P. Underwood
D. P. Leiberman	C. J. Watson
G. Llewellin	T. L. S. Williams

POSTGRADUATE DIPLOMA IN PSYCHOLOGICAL MEDICINE

R. H. S. Mindham	M. A. H. Russell

Part 4

M. K. Anto
T. S. Brown
Mary T. Cunningham
J. R. Gibbs
M. F. Hadoke
Helen Hale
M. I. L. Joseph
R. N. Kirby
G. Llewellin
T. MacLennan
C. P. Malpass
D. B. Mathias
C. A. C. Pickering
Theresa D. Pietroni
T. Roe
M. F. Rumpus
W. Snidvongs
T. D. P. Underwood
T. L. S. Williams

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

Fellowship

G. J. Amiel
V. Bockner
R. L. Edwards

Membership

M. K. Dunstan
P. S. Firth
R. C. Francis

D.Obst.

Margaret E. Abel
P. McC. D. Anderson
J. H. M. Axton
D. J. Boulton
D. L. Carle
P. G. Kelly
D. M. Lewsey
P. F. Sievers
M. Singh
Jillian M. Wandless
S. M. Wood

PERSONAL

I HAVE practised in Johannesburg for 30 years and plan to retire. Are you looking for an opening as assistant and future partner in a lucrative and selective dental practice in this land of sunshine and promise.
Write: Dr. C. Pedley, 1410 Rand Central, Jeppe Street, Johannesburg, South Africa.

WANTED. Unfurnished accommodation from October 1st for small family near Guy's. Dr. P. A. Trott, Path. Lab., Royal Sussex County Hospital, Brighton. Tel. 66611.

LEICESTERSHIRE. Young Dental Surgeon required as Assistant/Associate from July to December, 1966, inclusive. Busy county practice situated in Market town. Fully furnished flat above surgery; car park opposite. Please write Box No. 752.

CHANGE OF ADDRESS

LILLICRAP.—Dr. and Mrs. D. A. Lillicrap, to 29, Princes Garden, Cliftonville, Margate, Kent.

BIRTHS

CURTIS-RALEIGH.—On 2nd May, 1966, to Jean (née Steadman, M.B., B.S., D.P.M.) and Nigel Curtis-Raleigh, a son, Giles.

TUDDENHAM.—On June 10th, 1966, at Barton Maternity Home, Hants, to Jean (née Richards, S.R.N.) and Dr. Malcolm Tuddenham, a daughter, Kim Diana.

NEAL.—On May 20th, at St. Francis' Private Hospital, Leicester, to Sally and Dr. M. J. Neal, a daughter, Victoria Emma Clare, a sister for Adam.

SMALLSHAW.—On 13th May, 1966, at Nuffield House, to Buddy and John Smallshaw, a daughter, Amanda Louise, a sister for Thelma Jane.

DEATH

SPURRELL.—On June 7th, suddenly, at his home in Parkstone, Professor Walter Rowarth Spurrell, F.R.C.S., dearly loved husband of Dorothy, née Griffith, and father of Joan, Rosamond and Richard.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

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SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2033

PASSIM

New Jobs for Old

For too long, now, the clinical rat-race for jobs has tended to sour an otherwise stimulating and enjoyable course, and perhaps the most gratifying aspect of the New Plan for the House Jobs lies in its potential effect upon the atmosphere at Guy's. Sometimes there have been too many deserving applicants for the number of jobs available, while at other times jobs have been given to applicants who by comparison did not seem to merit them. The sign-up system upon which these decisions depend has often been held to ridicule by students who felt that their future was being decided by Consultants who sometimes did not even know their names. By increasing the number of jobs in the first six months, the Medical Committee will have done much to lessen these instances of complaint, yet by wisely not giving everyone an appointment they will have retained the sense of honour and achievement that has always been attached to getting a job at one's own hospital. The net effect upon student attitudes should be all to the good, decreasing the need for toadying and helping to encourage a mature and more questioning approach.

In all its other aspects, too, the plan appears both sound and timely, and provided the period of transition can be got over without difficulty, those qualifying in the future should benefit greatly for the change.

(We publish, on page 350 in our correspondence columns, a letter from the Acting Superintendent giving details of the Plan.)

Finals—How Final?

"Medical educators are generally aware that there is an imperfect correlation between academic success and later performance in practice." This remark appeared in an introduction to a study of General Practice in North Carolina, U.S.A., 1953-54—a study which eventually supported this hypothesis. While there was some significant correlation between undergraduate academic rating and standard of subsequent practice up to the age of 35, i.e. a relatively short period in professional life, this correlation subsequently disappeared as age and experience tended to bring performance ratings towards a mean.*

The results of this study, subsequently supported by further studies, demonstrate yet again that the manner in which medical students are examined is still largely alien to an accurate assessment of the quality of the future doctor. Despite the overwhelming evidence, the trip to the examination hall still evokes the age-old

*J. Med. Educ. 31: No. 12, Part 2 (1956.)

mental excesses, both cortical and hypothalamic, payment of large fees, deterioration of health and interference with current work, all for a system that does not achieve its primary purpose. (If levels of pass marks bear no future relationship how can the failure level do so?). One cannot help but see in yet another cloak the apparently entrenched adage , "I went through it, etc."

Indeed, what we have referred to recently as the "narrow-minded Lucifer", Finals have become a religion in themselves, having last year even produced a catechism "How Not To Fail The Finals"—price, mind you, a mere 7s. 6d. So that students not only subject themselves to being examined in an irrelevant way but also have to study the method by which they are examined, and can be held back from entering upon professional careers through failure in either of those two aspects.

Passim has previously commented on the folly of the supposedly standardized London M.B., B.S. degree which has probably the most academically based examination system. For certainly Conjoint makes a slightly better attempt at assessing current ability. Oxbridge Finals have the appearance of Saville Row pageantry, while the Worshipful Society continues to offer a last ditch stand.

To the defending question, "With what do we replace it?", there are many suggestions. Assessment should be made far more frequently, preferably at the end of relevant appointments *without* the final professionally surrealistic situation where the whole and detail of knowledge are required to be at the hand of pure memory in the space of a few hours. Another, recently expressed at the Royal Free Teach In, would be the reversion to a method of education on the old apprenticeship lines, qualification being determined by and the responsibility of both apprentice and mentor.

Not that one dreams of immediate adoption of such suggestions, yet there certainly must be as much attention given to the measurement of future professional ability as to any change in the way is it created.

Recent question in Oxford M.B.:—

Give the name of one eminent medical man who was closely associated with each of the conditions listed below. Write three lines of biography about each man:

(i) Iron deficiency.
(ii) Glomerulonephritis.
(iii) Coeliac disease.
(iv) Bacterial endocarditis.
(v) Myxoedema.

Dying in Hospital

". . . . . die in good company;
for dying is a lonely occupation."

Edwin Brock.

Hospitals have always been places in which people sometimes died. Today, under our Welfare State, they seem to be becoming the death-place for more and more of our population. In planning for their future, it would be well to consider the merits of this trend and to think how one might improve their facilities so that they might accept this function more appropriately.

The question whether it is desirable for any individual to be sent to die in hospital is usually the problem of the General Practitioner, and is solved as a rule by considerations of expediency such as the need for nursing or regular medication or anything which cannot adequately be provided in the home. In most such instances, a hospital is the most physically comfortable and socially sensible place for death to occur. Few of us would, however, deny that for some this is emotionally an unfortunate thing to happen. To be taken from the familiar surrounds of one's home, one's family and personal doctor and delivered into the hands of a busy hospital staff, must be for many a depressing and lonely way to spend their last days. However, for others, who have had no family about them before they were admitted, it may be an improvement for which they are grateful.

At Guy's as elsewhere when patients are critically ill, husbands or wives are allowed to spend as much time as they like in the ward and this arrangement suffices in most cases. There are some instances, however, in which it would be a real service if the hospital could routinely provide overnight accommodation for a relative in much the same way as the more progressive hospitals allot beds to the mother when her child is admitted.

For us to design and plan for this facility might seem extravagant in this age of credit squeeze and stringent evaluation. Yet our morphia and sweating polythene are only meaningful in that they can bring relief to physical suffering. Our duty lies in providing comfort and solace for the dying patient on all levels and in helping his family to be near him we would not (as sometimes happens now), make him pay for his treatment with isolation.

GUY'S DIARY

JULY		p.m.	
11th	M.	1.00	Clinical Lecture: Dr. SAXTON. "The Scope of Intravenous Urography".
12th	T.	1.00	Clinical Lecture: Mr. ECKHOFF. "Deformities of the Hands". Part II.
14th	Th.	1.00	Clinical Lecture: Mr. LAWRIE. "Carcinoma of the Pancreas".
15th	F.	1.00	Clinical Lecture: Professor TROUNCE. "Patterns of Prescribing".
18th	M.	1.00	Clinical Lecture: Dr. BAKER.
19th	T.	1.00	Clinical Lecture: Dr. BISHOP. "Conceptives and Contraceptives".
21st	Th.	1.00	Clinical Lecture: Mr. BLACKBURN. "Gastrointestinal Bleeding".

Neurosurgical Round: Thursday, 21st July, at 5 p.m. in the Clinical Theatre—Mr. PETER SCHURR.

Clinico-Pathological Meeting: Saturday, 23rd July, at 10 a.m. in the Clinical Theatre.

*A GENETIC APPROACH TO INVESTIGATIVE DERMATOLOGY

by

R. S. Wells, M.D., M.R.C.P., D.C.H.

Institute of Dermatology, St. John's Hospital, London, W.C.2.

In the last fifty years few branches of knowledge have expanded so rapidly as the study of genetics. Pure genetics has been defined as "a statistical science based upon probability phenomena" or as "a study of inherited variation" and human genetics as "a study of inherited human variation", and it is now impossible for any one person to cover the whole field. Sub-divisions, such as cytogenetics, have become studies in their own right and this tendency will obviously continue in the future. I would like to discuss the problems that face a human geneticist.

Man has several disadvantages from the genetic point of view, families are often small and generally only two or three generations are available. This difficulty can be overcome to a certain extent by obtaining information from many sources and through the study of large pedigrees or large numbers of pedigrees. Dermatology has some advantages compared with other branches of medicine because many of the manifestations of abnormal genes will be visible.

Human genetics has passed through three phases. In the first it was considered that the genotype was responsible for the phenotype. This was followed by the concept that there was one gene for one enzyme and finally, with the greater understanding of the genetic code, it is possible to study aminoacid sequences which give rise to protein molecules.

The most important function of a clinical geneticist is to determine the mode of inheritance of genetically determined disorders, and it is therefore often convenient to think in terms of a genotype being responsible for the phenotype. If a clinical geneticist studies the whole field of human disorders he will generally have to rely on the clinician for a correct clinical diagnosis. There is a very rare skin condition called ichthyosiform erythrodermia, and if, for instance, a patient is referred with this diagnosis then the geneticist will say that the mode of inheritance is that of an autosomal recessive trait. This condition has sometimes been wrongly diagnosed as pityriasis rubra pilaris and if this same patient is referred by another clinician with this diagnosis the inheritance will be stated to be that of an autosomal dominant trait. It may therefore be justified for one clinician to have

* A lecture given in the course on The Biology of the Skin, at the University of Cambridge and also to pre-registration House Officers at the Royal College of Physicians.

a special knowledge of a group of diseases in which he may be able to assist with diagnosis as well as genetic advice, in other words a dermatologist with a primary interest in clinical genetics. At the present time, much of this work will be concerned with research rather than direct clinical application. It is important to collect full, accurate information which, although it may not be necessary for the immediate treatment of the condition, should be recorded for further analysis. There are many instances in the literature where research workers, such as Haldane on xeroderma pigmentosum, have drawn the wrong conclusion because the basic data were inadequate.

Ascertainment of patients

Although the rare case can be regarded as an experiment carried out by nature it has been assumed that many geneticists are only interested in seeing unusual and difficult conditions (" stamp collecting "). This is a fair criticism because bizarre syndromes can be easily recognised and their genetic character determined. In addition, seeing large numbers of human beings with common conditions is time consuming and expensive but it is absolutely necessary to do this in order to obain adequate clinical data, and there is, therefore, always a problem of ascertainment.

Some time ago I devised a diagnostic index[1] to be used in Dermatology Out-patient clinics which is now widely followed in this country and abroad. I hope that in the future it will be adopted as standard throughout the Oxford Regional Hospital Board area and it would obviously be very useful if a similar uniform system could be used in the Greater London area. At the present time I am expanding and revising this index and a later edition will be set out in a form that is suitable for computer analysis of data. Although it will always be necessary to use other sources, such as general practitioners, if such a scheme were completed and if case material was available from all London hospitals then the problem of ascertainment would be solved and there would be more than enough clinical material to keep several geneticists hard at work for the rest of their lives. Such a scheme is already in operation in Denmark.

Classification

The first step in any scientific investigation is to devise an adequate classification. This, in itself, may suggest further research projects in other fields. For instance, at the present time, palm prints, scales and ophthalmological features of the different types of ichthyosis are being examined by other research workers using the genetic classification[2] which I devised as a basis for their studies. It may be possible to find phenotypic differences in all these investigations which may assist in the diagnosis of patients in the future.

Using a genetic classification to study histological features I was able to describe differences between the sex-linked and autosomal

dominant type of ichthyosis[3]. I have now collected more than one hundred sections from patients with all the different types of ichthyosis and it will therefore be possible in the future to write the definitive paper on the histological features of this condition, and to carry out a statistical analysis of the variation between the two common varieties Although such research is not primarily concerned with clinical genetics it will, nevertheless, enable the phenotype to be differentiated more precisely and it will therefore become possible to classify sporadic cases on their clinical appearance.

It is in the diagnosis of the sporadic case that the clinical features may help the geneticist. If a patient has bullous ichthyosiform erythrodermia and neither parent is affected then it is evidence of a fresh mutation because it is inherited as an autosomal dominant trait. The other children of these parents are unlikely to be affected, but on average, half the children of the mutant will have the condition. Alternatively, if the clinical diagnosis of a sporadic case is ichthyosiform erythrodermia, which is inherited as an autosomal recessive trait, then on average one in four of the other children of this marriage will be affected. Provided that this patient does not marry a close relation the chances of any of their children being affected are very small indeed although, of course, the gene will be transmitted until it is eventually eliminated from the population.

Many previous classifications have been unsatisfactory because they are based on such diagnoses as "collodion baby". This descriptive term may be used in any one of four different conditions, namely ichthyosiform erythrodermia, lamellar ichthyosis, sex-linked ichthyosis and bullous ichthyosiform erythrodermia, during an early stage of their development.

Analysis of data

One of the chief problems in dermatology at the present time is to give numerical expression to valid clinical observations. Many of the genodermatoses can be separated into three main genetical groupings and their clinical variation analysed statistically if there is a sufficient number of patients. At the moment my data for ichthyosis vulgaris and sex-linked ichthyosis[3] are undergoing discriminant function analysis by a statistician who has completed a thesis on this particular method. So far he has only dealt with a limited number of variables, and since with ichthyosis there are more than twenty statistically significant differences, computer assistance will be essential. This method can be applied to other disorders not genetically determined which appear superficially similar although it would be necessary to find one single criterion (for instance by conventional or electron microscopy) by which they can be distinguished. Such a test might be termed diagnostic but it still does not solve the problem of the degree of clinical variation that is possible with a particular entity. This again can only be determined by recording accurate information and studying large series.

Multifactorial inheritance

It is often stated that the inheritance of a particular condition may be dominant, recessive or sex-linked. While it is possible that the phenotype of different genotypes may superficially appear to be similar it is very unlikely that they will be identical and it should always be possible to define clinical differences after they have been adequately separated by their mode of inheritance. With large numbers of patients who were affected with ichthyosis vulgaris, it was possible to separate sex-linked ichthyosis as a distinct clinical entity[3, 4], and the hypothesis that a different genotype will be responsible for a different phenotype has always been shown to be correct whenever it has been tested. When disorders have been grouped on a genetical basis then histological, biochemical and other differentiating features follow a logical pattern and will be understood more exactly.

When two clinically similar conditions have the same mode of inheritance it may be possible to separate them on histological features. Again, it may be justified to distinguish conditions on purely morphological differences if it can be shown that one group has other important associations. For instance, the family with hyperkeratosis palmaris et plantaris in which several members died with a carcinoma of the oesophagus had the diffuse type of palmar thickening, rather than the linear or punctate. The inheritance and histological features of these three groups are essentially the same but it may be justifiable to distinguish them clinically because of the association with neoplasia. Apart from conditions such as these it is probably better to group genetically similar disorders together and to abandon many purely morphological diagnoses. It is still not known if intra-family variation is less than inter-family variation, which it certainly should be, but quite wide morphological differences are apparent even in one family who must have been the recipients of a single mutation. If, however, two conditions such as ichthyosis vulgaris and sex-linked ichthyosis are shown to be genetically, histologically and clinically distinct, then it is obviously unjustified to consider them together because of superficial morphological similarities, because they are due to different genes affecting different processes and controlling the synthesis of different molecules.

Monofactorial inheritance

With common conditions such as atopy (asthma, eczema and hay-fever syndrome) where the population frequency is one per cent or more, it is probable that several genes are involved, and Stevenson[5] has recently suggested this mode of inheritance for psoriasis. The characteristics of this polygenic type of inheritance are still being determined but careful family studies of atopy might well establish new criteria that would be helpful in family counselling. As with some single gene conditions the difficulty with both psoriasis and atopy is that there is no single test with which to establish the diagnosis in a patient who no longer has clinical lesions.

Other genetic investigations

Genetic counselling would be greatly assisted if several problems could be solved.

1. The detection of heterozygotes for lethal or serious conditions. If it were possible to establish that a man and wife did or did not have the same genes for recessive traits then a eugenic approach to marriage counselling might be possible.

2. The detection of carrier females. This is of great importance with haemophilia where it is still not possible to identify the carrier female before she has had affected male children. It might also be useful with conditions such as sex-linked ichthyosis, particularly if this is associated with oligophrenia, or Aldrich's syndrome and dyskeratosis congenita.

Chromosome abnormalities

During the last few years a considerable number of chromosome abnormalities have been described. It has been shown that different karyotypes may be responsible for the same phenotype, which is generally known as a mongol (Down's syndrome). It has been impossible to demonstrate clinical differences between mongols who have a differing chromosome constitution, but no study along these lines has been undertaken by a dermatologist. In two large mental hospitals all the mongols have had their chromosomes analysed, and I hope to investigate them carefully at some time in the future. Chromosome analysis is time consuming and expensive and to define clinical differences would be a most important contribution.

Present research

At the present time my research is primarily concerned with the two types of ichthyosiform erythrodermia, other rare forms of ichthyosis and X-linked dermatological conditions.

1. Bullous ichthyosiform erythrodermia and ichthyosiform erythrodermia. Again, these two conditions are genetically, histologically and clinically quite distinct and in many ways it is unfortunate that they are grouped together. Families are rare but I have already obtained twelve pedigrees of the bullous type with affected members in more than one generation and six pedigrees of the non-bullous type with more than one affected patient.

2. Ichthyosis and oligophrenia. I have recently seen all the patients in the mental hospitals in the south of England who are known to have ichthyosis. They can be classified in four main groups:—

A. Ichthyosis vulgaris which is associated by chance with many other syndromes.

B. The Sjögren-Larsson syndrome. The three features of this syndrome are ichthyosiform erythrodermia, spasticity and severe oligophrenia. Histological studies have confirmed the diagnosis of the skin condition.

C. One patient with a unique combination of ichthyosis of an unusal type, microcephaly and oligophrenia.

D. Sex-linked ichthyosis, oligophrenia and hypogonadism. I have now seen eleven patients with this syndrome and I postulate that one single biochemical defect is transmitted on the X-chromosome ("one gene one enzyme"), with variable expression in different patients. The most severely affected have microcephaly, a high-arched palate, an I.Q. so low that it is impossible to record and complete failure of secondary sexual development. In others the mental impairment is not so severe and two of the patients have an I.Q. that has been estimated at 80 and they live in the community. Clinical observers have repeatedly stated that they both have a peculiar personality in addition to being below average in intelligence. Some have a delayed bone age, bowing of the tibiae and four have had talipes equino-varus. Several have a low haemoglobin and bone marrow studies on one suggested that he had a toxic pancytopaenia.

All of these patients have sex-linked ichthyosis, often with the characteristic story that "they peeled all over" shortly after birth, and the skin histology supports this diagnosis. In babies with sex-linked ichthyosis without oligophrenia the trunk and limbs are affected with ichthyosis very early in life, but I think it is interesting that in this syndrome the thighs remain normal for much longer than usual. So far I have only scored the patients on the pedigrees as affected if they have sex-linked ichthyosis, but this will probably be an unsatisfactory diagnostic feature, because in one family with a severely affected boy one brother has oligophrenia and another oligophrenia and infantilism without ichthyosis. Until the biochemical defect has been defined it is impossible to differentiate the phenotype adequately and therefore linkage studies are not practical.

In another family a severely affected patient was known to have twin brothers aged six months. The marked general deterioration did not occur in the older boy until he was approximately one year old. When I visited the twins I found they both had sex-linked ichthyosis and they are attending the Well-baby clinic of a London Teaching Hospital. If, therefore, a biochemical defect is elucidated which can be treated in a manner similar to phenylketonuria then the ichthyosis may be used as a marker for the condition and it will be important to recognise the clinical appearance in the first few weeks of life.

While visiting hospitals for the mentally sub-normal I have become aware that many of their patients are undiagnosed in the ordinary clinical sense. These patients can be admitted into the wards of general hospitals and I would suggest that teaching hospitals should co-operate with some of the large mental hospitals and investigate their patients more fully than is done at the present time.

3. Other sex-linked dermatoses, to which the hypothesis may be applied that they have inherited a single biochemical abnormality, are dyskeratosis congenita, the other condition listed above and sex-linked baldness with keratosis pilaris. I have seen one family in the Midlands with the latter diagnosis and I am trying to find other patients. Such families will obviously lend themselves to a full study of biochemical genetics and it may be possible finally to unite the work of molecular biologist with that of the practising clinician. In addition such studies may shed light on the processes responsible for abnormal keratinisation and other dermatological abnormalities.

Conclusion

The problem with research on the genodermatoses is not what to do but where to begin. Although the biochemist and geneticist can investigate genetic disorders more completely than the clinician it is usually the latter who makes the first important observations and suggests where further research can be directed. I would like to end with a quotation from a paper by Sir Gavin de Beer who said: "It is worth pointing out that, of every one of the many branches into which genetics has fanned out, not one is a dead end; all are ever-widening, fertile fields for experiment and the acquisition of natural knowledge."

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PROFESSOR L. R. SPURRELL

— A TRIBUTE

The death of Roworth Spurrell brings to a close a deep and admiring friendship for many of us at Guy's, and to a host of Guy's students it means the passing of a great and inspiring teacher. Elsewhere accounts of the career of this most versatile person have emphasised the brilliance of his undergraduate and post graduate achievements. Who or what determined his spending a year extra studying physiology? Was it his own wish or the farseeing advice of Professor Pembrey, or was it just the natural thing to do when you are the most brilliant student of your year? How fortunate for him and for Guy's that he did! Those gaining honours in surgery in the M.B., B.S. examination were allowed to sit the M.S. examination after one year only. It was characteristic that he was successful in the final F.R.C.S. and the M.S. examinations within the year, and a career in surgery was before him. The surgical staff of the Hospital was invariably recruited from the Anatomy School, but now it seemed possible—no, certain—that the next appointment would bring a physiological light into Clinical Surgery. The disappointment that ill-health brought was widespread among his colleagues and contemporaries, but never a word of regret or self pity was heard. Then was revealed his great courage—first to get well enough to work and then to face the inevitable change of direction that ill-health ordained. Some more experience in physiology, a little delay in the retirement of Professor Pembrey and the succession in the physiology department was assured. For almost 30 years, including the extra burdens of the war years, he taught, he guided, he inspired Guy's students of all ages, who in their turn learned to love and respect him. Throughout these years there were periods when his health would have justified earlier retirement, but his courage, his determination and his unselfishness often made one feel ashamed of one's own inclination to self-pity.

It was not only for his teaching that Guy's Schools and Hospital are grateful to Roworth Spurrell as a bulwark of the school staff. His wisdom, his steadfastness and his utter disregard of self-interest made him an invaluable member of any committee, and at times of controversy an essential one.

We salute a great Guy's man, who might even have been greater, but we are thankful for what he was.

To his widow and family we send our sincere sympathy.

A Memorial Service to Professor Spurrell will be held in the Guy's Chapel on Monday, 18th July.

CORRESPONDENCE

House Appointments

SIR,—House appointments at Guy's and Associated Hospitals have recently been made fewer by the Medical Committee, who have recommended a new plan. This has been approved by the House Committee and I am asked to announce it.

The pre-registration requirements of one six months' appointment in medicine and another in surgery, of course, still apply. It is now decided that of these two pre-registration appointments, only one shall be held at Guy's Hospital, and as a general rule, this shall be the applicant's first house appointment. The second pre-registration appointment will be available at St. Olave's, New Cross, and selected regional hospitals, or may be held elsewhere if wished.

After registration there will be available at Guy's certain post registration house appointments, and some Senior House Officer vacancies as at present.

Each general medical and surgical form will have two house officers, each appointed for six months, one being changed each three months. The Department of Surgery House Surgeon will be appointed each six months as at present. There will be no changes in the grading of house officers to the Special Departments, except that the Paediatric House physician post may now be held at a first six months' appointment. The above will constitute the pre-registration appointments available to Guy's students.

The appointment of Casualty Officer will in future be for six months as a post-registration post and will be added to the present list of such posts available at Guy's Hospital.

There will be no change in the list of appointments at present available to Senior House Officers.

The proposed changes will enable more of our students to be given an appointment at Guy's. St. Olaves, New Cross and selected regional hospitals will be assured of a supply of first class house officers, who will benefit from working for a period in an atmosphere other than their own teaching hospital.

The decision that the first pre-registration appointment shall be at Guy's was based on the view that, being an extremely important part of a student's training, it should be the responsibility of the Guy's staff to supervise it, and further that Registrar supervision was likely to be of a higher standard at Guy's.

One further change has been agreed and that is the time of announcement of house appointments. These will now be published much earlier, and on the recommendation of a House Appointments Sub-Committee without waiting for ratification by the Medical Committee.

The change from the present to the new plan for house appointments will need a transitional period when both plans will overlap. The first changes will be among the appointments beginning December 1st next, and the completion of the changes should be achieved by March 1st, 1967.

R. J. CANN,
Acting Superintendent.

July 4th, 1966.

Thomas Hodgkin

SIR,—The letter from Dr. G. C. Davies (30th April, '66) prompts me to say that I visited Hodgkin's grave in 1964 and found the small granite obelisk and surrounding railing in good condition. It is in a disused and overgrown graveyard behind the Tabeetha School of the Church of Scotland in Yeffet Street, Jaffa (a suburb of Tel Aviv). Medical visitors to Israel may wish to see it. The key must be obtained from the Minister of the Church of Scotland.

Chase Farm Hospital,
Enfield,
Middx.

Yours, etc.,
C. ALLAN BIRCH, M.D., F.R.C.P.,
Consultant Physician.

Sunshine But What Promise?

SIR,—It is with a sense of the most profound and sincere regret that I write this letter, after reading an advertisement in the personal column of the *Gazette* for June 25th, 1966, in which a South African dentist on the eve of retirement advertises for an assistant and future partner " in this land of sunshine and promise." The regret is made all the more poignant by the fact that I, like many other Guy's men, have long cherished affectionate and admiring links with South Africa, based not only on the traditional association between this Hospital and that country, but particularly upon the special link with the Rugby Club which generations of South African students have done so much to enhance.

But tradition and affection cannot release a friend from the responsibilities of honest opinion, nor provide an excuse for expedient silence when this amounts to sheer moral cowardice. The fact is that under the Government of Dr. Verwoerd, South Africa, while still a land of sunshine, promises nothing at the present but continuation of a monstrous evil and injustice, and for the future the increasing possibility of a civil war. This is where the general policy of suspending even the pretence of justice for the majority of the inhabitants of South Africa is leading. Examples, with which every resident of South Africa must by now be sickeningly familiar, range from indiscriminate house arrest to the possibility of successive periods of imprisonment, without trial, in solitary confinement for up to one hundred and eighty days at a time.

I have hated writing this letter, and I read and sign it with a sinking heart. But it had to be done.

Yours, etc.,
DR. D. STAFFORD-CLARK.

York Clinic,
Guy's Hospital.

"Progress ?"

SIR,—It was with great interest that I read that the Guy's Nursing Training had been reduced from four years to three years and three months. It would be even more interesting to know of the motivations behind this change of policy.

To many of my colleagues, the fourth year was of vital importance to one's Guy's training. It was a period of increasing responsibility. After qualifying, one could check drugs for the first time and help the student nurses with their " Records of Work." A period of night duty rapidly followed, and during the night watches the new S.R.N. could acclimatise herself to her new status, in familiar surroundings. After this, as an Assistant Staff Nurse, she worked closely with a Ward Sister, who taught her so much about Ward Administration. Here may I digress and offer my grateful thanks to Sister Crump, of Diplock Ward, who gave me a bountiful store of good advice, which is still being used.

What a wealth of experience can be gained at Guy's. It was difficult to gain more than a small share of it, during four years, and it must be even more difficult now. According to my calculations, taking into account the 42-hour week, the total Guy's training has been reduced by 46 weeks.

I only hope that the esteem with which the Guy's nurses are held throughout the world, will not suffer because of "progress".

PATRICIA BURGESS, S.R.N., S.C.M., O.H.N.C.
(Guy's, 1958-62)

120, Field Road,
Feltham,
Middlesex.

The Stephen Truscott Case

SIR,—C. R. Neve's very nice letter of April 29th calling for a review of Isabel Lebourdais' book on the case, and suggesting that I might be interested comes a little late in a campaign that promises to vie with that of the Evans case in this country. A review by me at the request of the Editor of the *Medico-Legal Journal* has already been published, and will no doubt circulate in Canada. I happen to have had the advantage of reading the transcript of the trial as well as the book.

The Editor of the *Medico-Legal Journal* (himself an old Guy's man) sees no objection to the *Gazette* reproducing what was written there, if the *Gazette* Editor accedes to Mr. Neve's request, and I myself think that it may do something to create a calmer and more dispassionate view of the case. Emotion is a disturbing element in a judicial procedure, difficult—but important—to eradicate.

Yours, etc.,

KEITH SIMPSON.

23rd June, 1966.
Dept. of Forensic Medicine.

(Copy of Review by Keith Simpson, now in print in current number (2) of 1966 *Medico-Legal Journal* of " The Trial of Stephen Truscott " by Isabel Lebourdais. Published by Gollancz, June, 1966.)

This critical review of a Canadian case in which a fourteen-year-old boy was found guilty on trial of the sex murder of a twelve-year-old R.C.A.F. family's daughter, is so biased by the outraged feelings of the authoress that it is difficult to weigh the facts. The girl's body was found in a wood some days after she had last been seen in the company of the accused boy, and he, it seems, lacked evidence in support of the rather colourless defence put up by Frank Donnelly, a virtually unknown lawyer who was briefed by the family. No figure appeared on either side. The case was, except for the youth of the parties concerned, just like so many others, and one wonders why it was selected for such a meticulous scientific dissection. Isabel Lebourdais complains of the injustices " of the weight of a state machine as against the comparative isolation of a defence lawyer", but funds seldom allow otherwise when the defence has nothing in its hands. The fact that the accused was a boy of fourteen has little to do with her case. She unfortunately relies upon extracts verbatim from, and repeatedly envokes the aid of, two historical Scottish text books of forensic medicine of 1938 and 1939, the latter still, of course, bearing the misleading title " Recent Advances in Forensic Medicine." This hardly adds substance to her argument. The medical and scientific evidence given seemed to us surprisingly sound coming as it did from quite moderate experts, and we do not subscribe to the feelings of outrage that are repeatedly called for in this account of the Truscott case.

KEITH SIMPSON.

Re-starting the Bridge Club

SIR,—It has been thought for some time that the Guy's Hospital Bridge Club, which was dissolved in 1961, should be re-formed. We should like to go ahead with this, with a view to participating in University and other competitions, but before we do so we would like to know how many people will support this venture. We would be grateful, therefore, if all those interested, including beginners, would contact us, either personally or by note.

Yours, etc.,

M. A. PREECE.
R. C. ILLING.

East Wing,
Guy's Hospital.

Apathetics Anonymous

SIR,—In your last edition you again created a platform for the perennial cry of " student apathy." May we analyse this a little more fully.

As I understand it, "apathy" is taken to mean non-participation of the majority in the myriad interests of the minority, whether they be organisers of sports day meetings, river boat shuffles or iced lolly tasting sessions.

We all have our little *tours des forces*, just as surely as we all have our crosses to bear, and I cannot see why we may not pursue our own delights without being railed at for not slavishly following those of others.

If someone wishes to run for three miles, around a grass hades, only to finish at the place he started, who am I to deny his right, but to ask me to witness such a futile spectacle, and subsequently to upbraid my refusal, is really more than my literary apathy can take.

Apathy is surely a relative quality and not an absolute one. I suspect the whole subject to stem from proponents of some Fascist principle of mass demonstrations of loyalty to causes held dear to sundry would-be demi-gods.

For some time now I have been searching for members for my new club, " Apathetics Anonymous ", but I can't persuade anyone to come along. You see, everybody is too apathetic.

Yours, etc.,

ROGER DAVIES.

1st July,
Dental Department,
Guy's Hospital.

Who Said Anything About Apathy? :—

Recent request to the Editors: *" I would suggest that you can improve the circulation of the "Gazette" to students, if you place the copies outside the Spit rather than in the library, which is not visited by many students."*

Dull Gazette

SIR,—Your *Gazette* is widely read by *all* sections of the hospital staff. I was delighted to see that the nursing staff are to make contributions to its columns.

With all due respect, your *Gazette* is often inexpressivly dull, the usual practice being to look at the last page, the correspondence, and Passim, then chuck it into the waste paper basket. This is not conducive to keeping a rising circulation and income.

As well as giving the cover a new look, I wonder if the new look could be extended to the contents, giving matters of interest which cover the *whole* hospital, which are particularly interesting to all the Guy's folk who have left the hospital. While appreciating that it is a student's magazine, run by the students, could it have a section for academical matters only? Live with the times, Guy's *Gazette*!

Yours, etc.,

M. S. GRIFFITH.

" Moonrakers ",
Mawgan Porth, N. Cornwall.

NOTICES

The Hunt Memorial Library

Dr. George Herbert Hunt was appointed to the staff of Guy's Hospital in 1913. As a physician he was particularly concerned with the growing speciality of cardiology, but his achievements and authority in this field were cut short by an early death from malignant disease in 1926. As a memorial to him, a library devoted to his speciality was opened in 1927 on the top floor of the medical block, or Hunt's House, named after a previous benefactor. Next door was the Cardiac Department, which consisted of Dr. Maurice Campbell, and an electrocardiograph, an 8-foot long optical instrument operated by Mr. Frank Muir as technician, and a small dark room for developing the glass plates on which the deflections of a string galvonometer were recorded.

During the war the bomb, which demolished the main staircase of Hunt's House, also damaged the Cardiac Department and the Hunt Memorial Library. The contents of the library were salvaged by Mr. Muir—Dr. Maurice Campbell was then Medical Superintendent of the Guy's war-time unit at Orpington—and electrocardiograms were taken in Dr. Ryffel's department of Clinical Chemistry. After the war the Cardiac Department was housed on the third floor of out-patients, and although the memorial plaque and the fine portrait of Dr. Hunt by W. Rothenstein were there displayed, there was no room for the Memorial Library.

Happily, owing to the co-operation of Professor Butterfield, the Hunt Memorial Library has now returned to its original site on the top floor of the medical block, opposite the well-equipped investigation laboratory shared by the Department of Medicine and the Cardiac Department. The library is used for seminars and tutorials—the Wednesday meeting of the Cardiac Department has met there for the the last two years—but it should be known that the collection of cardiological books and journals are available to be read there. The re-assembling of the library, its care, and the collection of a series of cardiological and electrocardiograms for teaching purposes is in the hands of Mr. Frank Muir, who retired from the post of Chief Technician last year after 53 years' service to Guy's.

The Hunt Memorial Library used to be a quiet place where one could work undisturbed for an evening and, although it now has other uses during the day, it is once again available for its original purpose to those who would like to use it, and their meditations need not be confined to cardiology.

The present policy of keeping the shelves unlocked at all times must depend on users reading the books and journals in the library, and not taking them away. It is a reference and not a lending library.

C.G.B.

MISSING VOLUMES FROM THE HUNT MEMORIAL LIBRARY.

The following volumes are missing from the Hunt Memorial Library. The Cardiac Department would be grateful if they could be quietly replaced by anyone who finds that he has them:—

Circulation:
1962 Vol. 26 (Nos. 1, 3, 4, 5 and 6.)
1964 Vol. 29 (Nos. (Nos. 5 and 6.)
1965 Vol. 31 (No. 5.)

British Heart Journal:
1964 Vol. 26 (No. 6.)

American Heart Journal:
1965 Vol. 70 (No. 6.)

American Journal of Cardiology:
1965 Vol. 15 (No. 2.)
Vol. 16 (Nos. 2 and 6.)

C.G.B.

28.6.66

ENROLLED NURSING

by

Miss J. McWhirter

Matron, New Cross Hospital

New Cross Hospital, at one time known as the South Eastern Fever Hospital, was approved by the General Nursing Council as a training school for Pupil Nurses in February, 1954, and we opened our first school with three pupils.

This two-year course provides the opportunity to undertake a short course in nursing providing all the practical nursing skills without the more academic requirements of State Registration. It is of interest to girls who do not wish to undertake a longer course, and it also has an appeal to older women who would find it difficult to undertake the academic study required for the three year course.

When the training school was established there were four wards open—two medical, two geriatric, and the Out-Patient Department, which also dealt with minor casualties. Our first three pupils gained experience in the above unit, being sent to a residential nursery in Lewisham for eight weeks' instruction in the care of children.

Wards that had been closed were opened gradually to provide more geriatric beds, bringing the total to five wards for this type of patient.

In 1960 we were able to include surgical experience in the training course by seconding the pupils to St. Olave's Hospital for 12 weeks, where they now spend eight weeks on the male surgical ward, and four weeks in the Casualty Department.

Experience in the care of children was reviewed, and a transfer was made to Goldie Leigh Children's Hospital, Abbey Wood, enabling them to gain experience in the nursing of sick children.

In the early days, Sister of the Out-Patient Department undertook the duties of Nurse Tutor until the appointment of an Administrative Sister and Sister Tutor (combined post) was made in 1956.

In May, 1962, the Guy's Unit (which occupied six of our wards) moved back to its parent hospital, and it was our task to take over and staff four of these wards—two accident rehabilitation and two orthopaedic—and the Theatres. This we achieved by early 1965, thus enabling us to provide a more interesting and varied experience for our pupils. At this time 11 wards were open, and 74 pupils in training.

The work and character of the hospital has changed a great deal over the last 12 years, all wards working at much higher pressure, and a greater turnover of patients. We try to keep abreast of all modern working conditions and have benefited from the syringe and sterile pack service given by Guy's.

The syllabus of training for pupil nurses is varied and comprehensive, and during the two years the nurse gains experience in all aspects of nursing care. As far as possible, theory is allied to the diseases nursed, and visits are made frequently to the wards by the tutors and pupils.

At present we have four intakes a year—February, May, August, and November, with an average of eight pupils per school. This ensures that the pupils will have completed the necessary 18 months or more before taking the Assessment, which is held in March and September.

The introductory period is for five weeks, the school day beginning at 9 a.m. and finishing at 4 p.m. During this period the pupil spends one half day on the ward each week—either a morning, afternoon, or evening.

Sub-divided, the experience covered during the two years is listed below:—

Introductory period	5 weeks
Medical Nursing, Male and Female ...	16 „
Geriatric Nursing, Male and Female	16 „
Rehabilitation, Male and Female ...	10 „
Orthopaedic, Male and Female ...	12 „
Children's Nursing	8 „
Male Surgery	8 „
Casualty	4 „
Out-Patient Department and Theatre	5 „
Night Duty	12 „
	96 „
Annual leave	8 „
	104 „

The teaching programme is planned so that pupil nurses do as much practical nursing on the wards as possible, so that they feel they are really doing what they set out to do, namely, care for people. The syllabus is planned to cover the requirements of the General Nursing Council, and at the same time to meet the needs of the hospital. During the five week introductory course, as much time as possible is spent, under supervision of the tutors, in practising procedures taught in the classroom or demonstrated on the ward.

There is good co-operation from the Ward Sisters, who allow the tutors to visit and supervise the nurses at any time.

Apart from the period under supervision of the tutors, each nurse is allocated to the ward where she will be working when she leaves the school at the end of five weeks.

Subjects taught in the introductory course.

(1) The nurse and professional relationships; ethics. The National Health Service and the part the nurse plays. Visits are paid to all departments of the hospital, and short talks are given by heads of departments. The Hospital Chaplain also talks about his work in the hospital. The Fire Prevention Officer spends one afternoon in the first week talking about fire prevention, the use of fire appliances if needed, and how to deal with a fire.

(2) Use of bed accessories, bedmaking, special beds, changing bed linen. Nurses visit the wards to strip and make beds under supervision.

(3) The basic nursing care of the patient, care of the skin, hair, mouth, and the importance of diet and serving food attractively. Personal hygiene. Films are shown to illustrate these subjects.

(4) The anatomy and physiology given is very simple, and only that which applies to the reason for the procedure being carried out is taught. At no time is detailed anatomy and physiology given.

(5) The hygiene of the ward, the importance of adequate heating, lighting and ventilation, and the need for ward routine.

(6) Observation of the patient, and the recording of observations are taught, also the importance of the ward report.

(7) The outline of the principles of first aid only are taught in the introductory course—further instruction is given later. Given below are details of a typical day at the end of the second week of the introductory course:—

9.45 a.m.—10.00 a.m.	Questions answered.
10.00 a.m.—10.30 a.m.	Coffee break.
10.30 a.m.—11.30 a.m.	Preparing and serving attractive meals, and feeding helpless patients.
1.15 p.m.— 2.00 p.m.	Lunch.
2.00 p.m.— 2.30 p.m.	Discussion on morning work.
2.30 p.m.	Nutrition—the need for a well-balanced diet.
3.15 p.m.— 4.00 p.m.	Private study, write up notes. Note taking is kept to a minimum, and pupils are encouraged to use their own words. The titles and subtitles are given as necessary.

At the end of the five week introductory course, a half-hour practical test is given on the ward—a Ward Sister acting as examiner. A short written test is also given.

Each nurse is seen by Matron at the end of the course, and her progress assessed, and guidance is given on the books to read.

The nurses are also encouraged to start saving a little each month towards their Assessment and Enrolment fee, and in this way they do not miss the money quite so much.

Future training

Once out of school the pupils have a break of one week from lectures, and return to the school for further training, either for one week in ten as at present, or as a study day every other week. This latter system will probably be adopted.

A gradual build-up of the cause, prevention and treatment of disease is undertaken during the two years, with practical demonstrations on the ward whenever possible. Talks by Doctors are given in the second year.

A break of three months is given towards the end of the first year to enable the nurse to do night duty.

At the date of the Assessment, about 20 months after entering the school, the nurse would have covered the syllabus, and be well prepared for enrolment.

REVIEWS

ELECTROCARDIOGRAPHY.

by S. A. Owen, M.D., F.R.C.P. English Universities Press Ltd. *Price* 40*s*.

Self tuition plays a necessary and sometimes painful part in acquiring knowledge. A medical student faced with the task of covering in three short years a vast course in clinical medicine embracing so many developing specialities has to rely on his own initiative for any unusual interests. Undergraduate teaching in electrocardiography is usually elementary and, indeed, it is argued that more is neither required nor desirable as it would necessarily displace more essential basic general medicine. For those undergraduates who may disagree with this or have a special interest in electrocardiography, or for postgraduates and practitioners who want to learn how to read an E.C.G., Dr. Owen's book provides a novel and experimental technique in self tuition. It is in the form of short paragraphs developing an idea followed by multiple choice questions which test whether the reader can proceed to the next idea or whether he needs further explanation of the idea in a simpler manner. The reader thus proceeds slowly or quickly, setting his own pace, and turning pages back and forth, at each stage being tested on whether he has learned or not. The chapters take him through basic electrophysiology; the application of the limb and chest leads in determining the electrical axis of the heart in the frontal plane; significance of changes in P, Q.R.S. and T deflections and the S.T. segment; disorders of rhythm; myocardial infarction and much else. It will be apparent at once that the book cannot be used for casual reference, but for the patient reader who follows the text, there is much sound and up-to-date information based on reliable theories. It remains to be seen whether the technique used is successful —it certainly deserves a try. The programmed "teaching machine" for which the original text of this book was written by the author has been in use at Guy's and has impressed many of those who have had access to it.

R. N. Maini.

CONVERSATION WITH YOUR FOREIGN PATIENT.

A. D. Forman, L.D.S., R.C.S.Eng.

This brief but extremely comprehensive manual should prove a useful adjunct to cosmopolitan dental practices and casualty departments where the patient is simply seeking alleviation of toothache. It comprises eight European languages, including English, which are divided into parallel columns and sections for easy reference. By pointing to the required questions, and replied to by the shaking or nodding of the head, the dental practitioner may elicit information concerning patients' symptoms, medical fitness and suitability for anaesthesia, should extraction be necessary. Local and general anaesthetic and extraction procedure is described in comforting terms, followed by a few sentences on complications which may thereby have arisen. Finally, the question of fee is tactfully dealt with.

The author has combined simplicity with courtesy, and one could only wish that he had extended the columns to include Greek, as it is the most difficult task to establish any form of communication with members of this race.

J. HAWLEY.

NUTRITIONAL ASPECTS OF CARDIOVASCULAR DISEASES,

By Eörs Bajusz, Crosby Lockwood & Son Ltd., 1965, 244 pp. + XIX, 38 figs. + 4 colour plates, 436 refs. 55/-.

This is a highly unusual and certainly stimulating monograph. After introductory chapters on cardiac electrolyte physiology, lipid metabolism and a general review of the pathogenesis of atherosclerosis, the author settles down to discuss cardiomyopathies. He distinguishes between primary *necrotizing* cardiomyopathies, which result from disturbed myocardial metabolism, and secondary *anoxic* cardiomyopathies. Myocardial infarction due to coronary occlusion is the most common "cardiomyopathy" in the latter category. He then discusses primary cardiomyopathy in man, including that due to alcohol, endomyocardial fibrosis, endocardial fibroelastosis, beri-beri, viral myocarditis, hypokalaemic myopathy and a wide range of other non-vascular causes, but he does not mention the "obstructive" form of the disease.

The main body of the book is devoted to consideration of experimental cardiomyopathies induced by mineral and vitamin deficiencies, cardiotoxic compounds, hormones and certain pressor amines. The discussion of these experimental conditions is well illustrated by gross photograph, electronmicroscopy and histochemistry.

The main conclusion of this work is that experimentally-induced electrolyte disturbances (reduced K^+, Mg^{++}, Cl^-; increased Na^+, Ca^{++}), together with the administration of certain steroids, leads to various morphological expressions of cardiomyopathy. Furthermore, such electrolyte-steroid "conditioning" techniques markedly sensitize the myocardium to the effects of cardiotoxic agents, excessive physical exercise and stress. In the last respect, the author has clearly been influenced by Hens Selye's concepts of "adaptation", "calciphylaxis" and "conditioning-challenging" responses.

This is mainly a book for the reader who has a special interest in cardiomyopathies. Much of the interpretation is speculative—as doubtless it was intended to be—while the author's preoccupation with the role of sodium ions in cardiomyopathy should possibly be taken with a small grain of salt. Nevertheless, leaving aside these minor carping criticisms, this monograph is a stimulating and praiseworthy attempt to elucidate the pathogenesis of a baffling, obscure and heterogeneous group of diseases: this effort to impose order on chaos is much to be commended.

C. W. M. ADAMS.

NURSING SECTION

A Matter of Life or Death

The subject of cardiac massage has arisen many times in the past, but still there has been no decision made on whose responsibility it is to decide what steps should be taken in the event of a cardiac arrest. All too often, junior nurses are faced with this decision with only a few seconds in which to make it. Only those who have faced this situation, can know the feelings and fears that flash through one's mind in those few seconds—the patient; their relatives; what will Sister say; what will the houseman say? In some cases it is wrong to attempt resuscitation—in others it is wrong not to; therefore it could be said that it is safer, from the nurse's point of view, to commence cardiac massage immediately, than to await medical advice knowing this delay may diminish the chances of success if an attempt is then made. Is this the cause of the sometimes apparently indiscriminate use of cardiac massage and the inevitable verbal "post-mortems" later? Alternatively, some nurses find it somewhat upsetting to be told that if the patient in bed 6 has a cardiac arrest, resuscitation should be attempted, but if the one in bed 7 collapses, then it should not! What then is the answer?

How can the nurses be taught the correct procedure if the Nurse Tutors and Ward Sisters have no clear instructions on which to base their teaching? This situation puts increased responsibility on the shoulders of the Sisters and Staff-Nurses, not only in making the decision themselves if they are present at the time, but also being responsible for the decision taken by a more junior member of the nursing staff in their absence, either at meal-times or, more important (and more often) at night. This problem has increased since it has become necessary to leave a third year nurse, and on some occasions a second year nurse, in charge of a ward for an eight-hour shift.

The Royal College of Nursing has recently attempted to obtain some official opinion on this question from the British Medical Association, but have been told that this is a purely local issue: so what are we waiting for? It is time the nursing staff demanded some guidance on this from the medical staff! Some members are known to have strong feelings on this subject, but their views are only heard when there is an occurrence which brings it to a head. Is it not possible to bring this problem to a head now by a discussion amongst those most concerned?

The Nurses' Prizegiving

It has been announced that Her Royal Highness Princess Margaret has graciously accepted an invitation to attend the Annual Nurses' Prize-giving on October 4th, 1966.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister T. Kenny, S.R.N., S.C.M. (Royal City of Dublin Hospital) to Nuffield A Floor.
Sister R. I. Weir, R.G.N., S.C.M. (Glasgow Royal Infirmary) to Main Theatres.
S/Midwife J. Crowley, S.R.N., S.C.M., O.N.C. (St. James Hospital, Leeds) to Victoria Ward.
S/N A. M. Orchard, S.R.N. (Groot Schuur Hospital, Capetown) to Barnabas Ward.

CHANGES

S/N E. A. Bellamy from Night Duty to Dental Outpatients Department.
S/N M. Fairlie from Esther to Night Duty.
S/N J. Homan from Samaritan Ward to Surgical X-ray Theatres.
S/N E. A. Mumford from York Clinic to Samaritan.

DEPARTURES

Sister B. Ford from Main Theatres.
Sister J. A. Foulkes from Main Theatres.
Sister G. M. Greensmith from Samaritan.
Sister B. Sweet from Victoria Ward.
C/N U. Lowth from Night Duty.
S/N M. Arnott from Main Theatres.
S/N J. Ashton from Astley Cooper Ward.
S/N A. M. Beattie from Miriam Ward.
S/N M. Beckett from William Gull Ward.
S/N P. Bellad-Ellis from Barnabas Ward.
S/N H. Caldcleugh from Night Duty.
S/N G. Dunlop from Caleb Ward.
S/N M. Fundell from Night Duty.
S/N C. Heyworth from Job Ward.
S/N M. Knight from Luke Ward.
S/N D. Lavagna from Main Theatres.
S/N R. Mejias from Dental Outpatients Department.
S/N J. Morgetroyd from The School of Nursing.
S/N G. A. Morley from Sarah Ward.
S/N J. N. Nancarrow from Esther Ward.
S/N E. Shine from Cornelius Ward.
S/N A. A. Tyley from Dorcas Ward.
S/N A. Yorke from Surgical X-ray Theatres.

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SPORT

With the athletics team having retained their University of London and United Hospital Championships, and the Cricket XI's being knocked out of their respective Cricket Cups, sporting activity has taken on a less important aspect of hospital life over the last few weeks.

The 1st XI have been weakened during their last few games with various people taking examinations of one sort and another. Unfortunately the weather has not been so kind either, and two of the team's matches due to be played on two of the more pleasant grounds of Kent were affected by rain. Firstly the game against the Madhatters on the Nevill ground at Tunbridge Wells was abandoned without a ball being bowled. On the following Saturday against the Mote at Maidstone, rain intervened with Guy's score at 69—2 when chasing a Mote score of 220 for 9 declared. The next day a much weakened Guy's team played at Addiscombe, only to be defeated heavily by 119 runs, being dismissed for 79.

Last Saturday, however, Guy's defeated U.C.S. Old Boys by 8 wickets after they had dismissed their opponents for 112.

On the Sunday, Guy's defeated Mayfair by 7 wickets, with J. Butchey scoring his second century of the season.

The 2nd XI have gone from bad to worse of late, being unable to score enough runs, and have lost two games out of three, being saved by the rain in the third.

Reference was made in the last *Gazette* to the poor number of entrants for the Tennis Club's Guy's Competition. This is a great shame when people cannot be bothered to support club competitions, as the standard of play will deteriorate, resulting in defeats for the club. A strong fixture list takes some compiling over the years, and to lose such fixtures because of poor attendance and lack of enthusiasm must be avoided.

The Staff v. Students' Golf Match is to be played on July 10th at Huntercombe, very appropriately fixed for the day after the British Open Championship at Muirfield. Perhaps the standard at Huntercombe will not be as high as at Muirfield, but the social side of the event will make up for balls lost, missed putts, etc.

As the date (July 23rd) of the Nurses' Cricket Match draws nearer, one hopes that the Nurses will be cleaning their boots and practising their strokes for what one hopes will become a successful annual event.

Finally it is with pleasure that we publish at long last a picture of the cup-winning Rugby side. Mr. C. W. Thorburn is included as an inset because he was absent when the photograph was taken by Mr. Pitts.

DIARY

CRICKET.

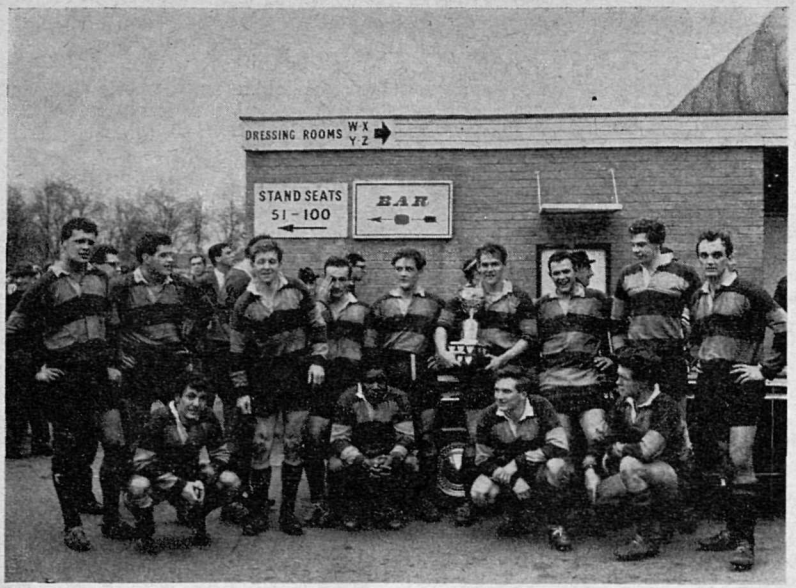
July: Sat., 9th—Nomads, 11.30 a.m. Home.
Sun., 10th—Streatham, 2.30 p.m. Away.
Tues., 12th—North of Ireland, 11.30 a.m. Home.
Sat., 16th—Metropolitan Police, 2.30 p.m. Home.
Wed., 20th—Thornton Heath, 11.30 a.m. Away.

LAWN TENNIS.

July: Sun., 10th—Shooter's Hill. Away.
Sat., 16th—West Hants. Away.
Sun., 17th—Winchester. Away.

GOLF.

July: Sun., 10th—Staff v. Students—Huntercombe.



GUY'S CUP-WINNING SIDE, March 17th, 1966

From left to right:—
Back row—M. Cockburn, P. K. Peace, A. L. Kingdon, M. Lindsay, P. G. F. Swift, G. Hey, J. E. Davies (Capt.), R. Stansfield, J. A. Edgar, H. C. Sharp.
Front row—I. Morgan, V. E. Egwuatu, D. Elliott, B. R. Rowlands.

Absent from above photograph
C. W. Thorburn
(Recently elected as captain for the 1966-67 season.)

REPORTS & RESULTS

CRICKET

GUY'S v. MOTE

Away Saturday, 25th June, 1966

Mote: 220 for 9 declared.
Guy's: 69 for 2. Rain stopped play.

Guy's won the toss and decided to field on a green looking wicket. The Mote started briskly until at 20 Clark had Pockock caught in the covers. Two overs later he had the other opener dismissed in the same way. Some competent batting by the number three and four batsmen saw the hundred up. However, a fine spell of bowling by Appleby (4 for 39), well supported by Clark and Beacham, enabled Guy's to get nine of the Mote's wickets down.

Guy's started at a good rate on a fine batting wicket. Gillham was caught in the slips for eight, but Clark and Butchey saw 50 up in even time. Clark was then caught behind, and Butchey and Griffiths batted until rain stopped play when the score was 69 for 2.

D. B. A. SILK

GUY'S v. ADDISCOMBE

Sunday, 26th June, 1966

Addiscombe: 189 for 9 declared.
Guy's: 79.

Away Sunday, 26th June, 1966

Addiscombe won the toss and elected to bat on a wet, green wicket. Beacham and Clark both made use of the wicket, and Kent and Houghton, opening for Addiscombe, both found it hard going. Kent was finally caught behind off a rising long hop from Beacham. Burrows was soon out trying to hook Clark and in the process of the shot standing on his wicket. Houghton began to get command of the situation, and by lunch Addiscombe had made 75 for 5. Some fine bowling by Turfitt

after lunch (4 for 45) put Addiscombe in trouble; a fine innings of 67 by their number eight batsman and some hard hitting by their number nine enabled Addiscombe to declare at 189 for 9.

The Guy's challenge on a now turning wicket started badly with both openers out for 13. Clark followed, caught behind off ? ? ? ?, the last over before tea. Silk and Appleby attacked the bowling after tea bringing up the fifty—the latter was out trying to hook for a bright 15. Then followed a procession, the longest stand being for the last wicket between Beacham and Silk. The latter being caught in the deep when the score was 79.

This undoubtedly was the poorest batting display of the season. It should be mentioned, however, that the wicket was the worst that most of us had ever played on.

D. B. A. SILK

GUY'S v. QUEEN'S, BELFAST

At H.O.P. Wednesday, 29th June, 1966
Guy's: 154 for 5 declared.
Queen's, Belfast: 155 for 4.

Guy's won the toss and elected to bat on a good looking wicket. Butchey and Gillham started steadily but unfortunately too slowly. Gillham was first out when the score was 45. After 75 minutes batting only 65 runs had been scored. Silk was soon out trying to push the score along. A fine attacking innings of characteristic fashion by Appleby, well supported by Clark, remedied matters. After Appleby was out, Clark continued pushing the score along, aided well by Thomson, and Guy's were able to declare with the score at 154 for 5.

Queen's, Belfast started slowly against the tight bowling of Clark and Beacham. Clark had one opener caught by Silk at mid-on, and Beacham bowled the other one. However, they quickly recovered, and their slow start was followed by some fine attacking batting by numbers three and four, the former hitting Beacham for six over his head onto the bank. Guy's managed to get two more wickets before they overtook our score—the main feature of Queen's, Belfast innings was the fine innings of 93 by their number four, and the running between the wickets which was an example to all of us.

D. B. A. SILK

GUY'S v. U.C.S. OLD BOYS

At H.O.P. Saturday, 2nd July, 1966
U.C.S. Old Boys: 112.
Guy's: 113 for 2.

U.C.S. Old Boys won the toss and elected to bat. Clark soon had one of their openers caught in the covers, and Beacham bowled the other. Soon afterwards Butchey accepted a low fast chance at third slip off Clark to dismiss the number three. He followed this soon afterwards by bowling the next batsman. At this stage U.C.S. Old Boys were 21 for 4. They then staged a recovery, but Beacham being brought back on at the end took three more quick wickets to dismiss them for 112. Beacham and Clark were well supported by Steer and Pierson who both bowled accurately and economically.

Guy's lost Gillham for eight at the start of their innings, but after this were in no difficulty. Some fine batting by Butchey (65 not out) and Appleby (36) saw the 100 up. Appleby was then out leg before, and Silk and Butchey saw Guy's home; Guy's winning by eight wickets, avenging last year's defeat.

D. B. A. SILK

BOAT CLUB

THE MAY AND BAKER CHALLENGE TROPHY

On Thursday, 9th June, the Boat Club were delighted to receive the "May and Baker Challenge Trophy" from Mr. R. W. E. Wood, General Manager of May and Baker Ltd.

The presentation ceremony took place, as Guy's tradition must surely demand, in the Bar.

The trophy is to be contested annually between Guy's and Bart's senior crews in the Hospitals' Boat Race. This event was at one time a great spectacle on the river and it is hoped that the presentation of this splendid cup will serve to arouse interest once more.

We must offer our most sincere thanks for the generosity of "May and Baker" and hope that the Boat Race will prove to be the exciting event we anticipate.

J. K. SKUSE,
Social Secretary, G.H.B.C.

GOLF

The President's Match, June 12th, 1966

Result: President's Team 5, Guy's 4

Foursomes:

D. Adams and M. Brummitt beat Mr. Lewys Lloyd and M. Christmas, 7 and 6.
P. Ellis and A. Philips lost to Mr. Brain and Dr. Anderson, 3 and 2.
P. Mewton and N. Curry beat Dr. Maclean and Professor Cohen, 1 hole.

Singles:

D. Adams lost to M. Christmas, 7 and 6.
M. Brummitt lost to Dr. Anderson, 1 hole.
P. Ellis beat Mr. Lewys Lloyd, 2 and 1.
A. Philips beat Mr. Brain, 1 hole.
P. Mewton lost to Dr. Maclean, 2 holes.
N. Curry lost to Professor Cohen, 2 and 1.

This annual fixture is now in its third year and Guy's have yet to register a win. However, the President fielded a strong team, including Martin Christmas, the Walker Cup player, and perhaps the Hospital did well to run them so close. The Tandridge course was in perfect shape and the warm sunshine made conditions ideal for low scoring.

In the morning D. Adams and M. Brummitt went round in 73 and duly won by 7 and 6. It was reported that the Adams' putter was red hot. In the bottom foursomes match the captain, P. W. Mewton, and N. Curry beat Dr. Maclean and Professor Cohen by one hole. The main hazard at the 17th hole used to be a gorze bush placed strategically behind the green. Dr. Maclean demolished it with three strokes of great power while the ball remained in much the same position. No one was surprised when Mewton and Curry won the last hole.

In the singles D. Adams found M. Christmas in ruthless form. M. Brummitt, resplendent in a striped green shirt which had been bought on a Spanish beach, was four down after twelve, but only one down on the 18th tee. He was robbed of his chance of a half when Dr. Anderson pitched stone dead with a 9-iron. The match between A. Philips and Mr. Brain was full of incident: from a distance of 200 yards your correspondent heard Mr. Brain exclaim that he was in terrible trouble. A putt of three feet on the last green gave Philips a good victory.

When the President beat the Captain on the last green victory for the President's team was assured.

P. D. M. ELLIS

HOSPITAL INFORMATION

APPOINTMENTS VACANT

HOUSE PHYSICIAN. Locum 18th to 31st August and six months' appointment from 1st September. Write with testimonials/references to Group Secretary, G.&D. H.M.C., Greenwich District Hospital, St. Alfege's Wing, Vanbrugh Hill, S.E.10, or telephone Hospital Secretary.

HOUSE SURGEON. Vacant 27th August; Six months appointment. National salary and conditions. Write with testimonials/references to Group Secretary, Greenwich and Deptford Hospital Management Committee, at Hospital.

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BIRTHS

MORGAN.—On May 3rd, 1966, at the Princess Margaret Hospital, Nassau, Bahamas, to Shelley (née Lloyd) S.R.N. and Richard Morgan, D.M.R.D., a son, Ross Lloyd, brother for Guy, Clive and Bruce.

HOUGHTON.—To Margaret (née Broughton) and John, on June 14th, a son, Peter John, brother for Janet.

DEATHS

PARK.—Alice Maud May, S.R.N., S.C.M., L.S.T.M. (aged 95 years), died peacefully in Guy's Hospital on Sunday, 26th May, 1966. Miss Park trained in the Guy's Hospital School of Nursing from 1898—1901. She held various appointments both at home and abroad from 1902—1943, including Ward Sisters' posts at Guy's Hospital.

PERSONAL

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EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2034

GUY'S HOSPITAL GAZETTE

PASSIM

For Whom the Bell Tolls

"Ethical principles are not a luxury . . . the essence of ethics—concern for the value of man—is indispensable for the survival of medicine as a profession and doubtless also for the survival of mankind as a species."

T. Rosebury.

Chemical and germ warfare continue to receive little attention from the public who have been left to regard the former as part of Great War history and the latter as merely Wellsian science fiction. The medical profession, through the privilege of education, have some idea of the terrible forces that this type of inhumanity can muster, yet appear unwilling to use this privilege to awaken the public to the Frankenstein that their politicians are currently nurturing.

A recent article in the medical press* detailed the methods available for such warfare with a chilling list of references. The range through history has been enormous from dead human and animal bodies in water wells through chlorine and mustard gas to modern chemicals which hide under such apparently innocuous hieroglyphics as DM, CN and CS. Irritants, vesicants, psychochemicals, oxidase inhibtors and nerve gases vie with the alternative bacteria, rickettsiae, viruses, fungi and toxins. Methods of disposal, detection, protection, decontamination and possible treatment are being studied and elaborated at this moment, and the public money being invested is ever increasing.

Through the centuries the medical profession has tended to adopt a passive rôle in matters of social and political importance. Its rôle in warfare similarly has been confined to treating the casualties. All this has been done from a Mount Olympus built on the Hippocratic Oath and decrees of its professional bodies. Until recently, there has been some ethical justification for this attitude. That persons with medical training should now be involved in producing lethal agents, however, represents a totally new departure which seems difficult to reconcile with those ethical foundations, if not a sheer misuse of knowledge unquestioningly imparted. It is high time the profession adopted a policy expressing not merely its disassociation with such methods of inhumanity but also its intentions of dealing with the matter in a manner that is able to produce some effect. Not least among these methods should be the awakening of

*New Engl. J. Med. 274: 1, pp. 21-27 (1966).

the public mind to all the aspects of the noxious agents involved, as it is only too obvious that the public mass media unguided fail in their duty by oversimplification if not simply melodramatising. To stand aside from the final use of such weapons does not indemnify against the participation in their production.

If the voice of Hippocrates is still to be listened to, it must be heard word by word:. . . "I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. . . ."

The Gazette, The Press and Guys

The Gazette is frequently, if not regularly, quoted by the Press. Representing a famous hospital and indeed, of its species of journal, being the oldest and most widely circulated in the world, it should perhaps expect a little attention. However, there are aspects to this situation that require further comment. For although it may be an advantage to obtain publicity for any views or activities of the profession that might be of general interest and contribute to the national good, whether they are announced in the *Gazette* or any other source, and especially when they are such items as we have detailed above, it is essential if embarrassment and even damage is to be avoided, for these items to be reported upon with either medical insight or accuracy.

Only recently, this point was clearly illustrated when the hospital was inundated with telephone calls and one gentleman even flew his invalid wife over from Egypt, following a gross misrepresentation by a National Newspaper of our article on Acupuncture.

This is not all. Often in Passim, or in our correspondence columns, views and criticisms are given that are of purely local concern and for these to be reported in the public press is not only meddlesome but also sometimes comes near to being an infringement of copyright.

If more newspapers saw fit to employ as many medical correspondents as they do crime or war correspondents, they would not only have advice on what to report from the medical literature but also they would spare both the profession and their readers from the consequences of their applied ignorance.

Dr. Evans Flies Back to Vietnam

Many of our readers will recall that Dr. P. R. Evans was sent to Vietnam last year by the Ministry of Overseas Development on a fact-finding mission concerning Child Health. On 26th of this month he is flying back to Saigon to lead a British team of doctors which is being sent out to help care for sick Vietnamese children.

From the recent headlines in the Medical Press it would seem that he is faced with an enormous task. For aside from the casualties of war the general health in that country is deteriorating rapidly, tuberculosis, amoebic dysentery, typhus, typhoid and malaria being endemic.

In this issue of the *Gazette* we are publishing Dr. Evans' account of this war-stricken country and its needs. We wish him and his team every success in their forthcoming venture and feel proud that Guy's, through him, is doing something to improve this difficult and tragic situation.

This week Guy's sadly bids farewell to Sister Chrimes. A tribute to her will be appearing soon.

ALICE MAUD MAY PARK, S.R.N.

Sister Alice Park died in Guy's in June, 1966, at the of 95. She was well known to generations of Guy's students as Sister Arabella. Few nurses have had so varied a life. After being a student nurse at Guy's she was appointed as a Surgical Ward sister for several years but resigned to become Matron of the General Lymington Hospital, York Road. From there she moved to Matron of the Civil Hospital in Kandy, Ceylon. Her next move was to a mining hospital in West Africa. On her return home she became Matron at a School for Cripples at Chaily. From there she emigrated to a mining hospital in North China, at Tongshan. Her last post at Guy's was Matron of the College at Guy's. For almost ten consecutive years she was night sister in the Medical Wards there. Deeply religious, she had a keen sense of humour and was greatly liked and respected, especially by all Guy's Residents and students.

J.J.C.

GUY'S DIARY

July		p.m.	
25	M.	1.00	Clinical Lecture. "Eczema in Infancy". Dr. MOYNAHAN.
29	F.	1.00	Clinical Lecture. "Chronic Bronchitis". Dr. SCOTT.

Clinico-Pathological Meeting: Saturday, 23rd July, at 10 a.m. in the Clinical Theatre.

Obiter Dicta.

One American student to another shortly after arriving at Guy's:—
"Put your tranquillisers away, it looks fine."

DESTINATION SAIGON

by

Dr. P. R. EVANS

Vietnam is a long coastal country fronting the South China Sea. It has existed for a thousand turbulent years. For the past twenty-five it has been almost continuously in a state of war against Japan, France or itself. Now (like Ireland, Germany, India and Korea) it is cut in two. North Vietnam is Communist. South Vietnam is anti-Communist. Its government at the moment consists of ten military men and ten civilians—two representatives of each of four religions and one of each of two political parties. Their rule covers the cities. The intervening countryside is the home of agricultural villagers, and it is for the control of the villages and the roads that Government and U.S. forces fight the Viet Cong (i.e. Vietnamese Communists) with arms, economics and ideas.

At the time of the division, Saigon, the capital of the south, was a large and important city, but under French rule it had been second to northern Hanoi. That was the site of the university, but fortunately for Saigon, many academics, although intense nationalists, were not Communists and so came south. This made the foundation of the University of Saigon possible and it already has a large and effective medical school with good standards. One of its requirements is eight months' study of paediatrics (half-time) and this is provided in Nhi Dong Hospital (Nhi Dong=children).

This hospital has a modern building (11 years old,) containing 242 cots, but each evening finds 400 children in them and the mothers on the floor beside them. There are not enough drugs or dressings. There are too few nurses. There are few senior doctors. The surgeon is now Minister of Education and Minister of Social Welfare, which sometimes leaves him free to operate as a relaxation on Sundays. In spite of the shortage of doctors generally (800, of whom 500 are in the army, for 15,000,000 people) the training posts are well manned. Each unit of 40 cots (70 patients) has a student interne, a qualified interne and the equivalent of a registrar. Most of the nurses and nursing technicians are also in training. The enormous out-patient clinic is largely cleared by mid-day—work starts at half-past five in the morning!

Many countries send aid to South Vietnam but the British effort has been, for good reasons, mainly diverted further south to Malaysia. Other countries in South-East Asia (e.g. Laos) have all the same

received quite a lot of medical aid from Britain and a suggestion was sent from Saigon to our Ministry of Overseas Development that we should try to help Nhi Dong Hospital. I was going to Singapore in November 1965, and was asked to visit Saigon on the way.

It is quite a pleasant city, with a port on the river, government buildings, a "West End" of sorts, residential district French style with trees and walled gardens, and a large Chinese city—in all 2,000,000 people. It is also noisy, hot, steamy and congested with cars, army lorries, mopeds, bicycles, cyclos (bicycle-rickshaws) and pedestrians carrying bundles and baskets. The national dress shows off the erect carriage and slim figures of the exquisite girls.

Much of the time was spent visiting people in their offices (innumerable handle-less cups of green tea) and enjoying hospitality, but I managed also to go on two ward rounds which were sheer pleasure because of the keenness and alert intelligence of the students and young doctors. I also gave a lecture in what I imagined to be French. Tuberculosis, encephalitis, haemoglobinopathies (blood sent to Paris for identification), haemorrhagic fever, protein malnutrition, sepsis and diphtheria provided food for thought. There was plague in the country but none in Saigon, and it was not the cholera season.

We have been asked to take over the surgery, to introduce chemical pathology using micromethods, and to provide general paediatric medical and nursing help—an isolated medical school, however good, always fears that it may not be up to date. The Ministry of Overseas Development is organizing a scheme to continue for five years at least, and has enlisted a team (une équipe pédiatrique —sounds like a bicycle team) in which each member signs on for 12 to 18 months. Initially it consists of six nursing sisters, all from children's hospital or units, a paediatrician, a surgeon and anaesthetist with special paediatric experience, and a chemical pathologist. The constitution is subject to evolution. Wives and children will come too. We shall live in flats or villas rented at inflated prices—paid by the British Government, not by the individuals. The average temperature is in the 80's and humidity in the 90's, but the bedrooms will be air-conditioned and electricity is likely to be on for five days a week. Interesting work and no fog, frost, snow or sleet, what more can one ask for? Most of the party will be there by mid-August but the pathologist and I leave on July 26th—one night in the air, one night in Bangkok, the third at our destination.

CORRESPONDENCE

Professor W. R. Spurrell, M.Sc., M.S., F.R.C.S.

SIR, I write on behalf of many Guy's nurses to express appreciation of the great debt which we owe to Professor Spurrell for the interest in, and influence on, the training of nurses at Guy's.

The School of Nursing may be said to have been "set on its way" when Mr. Eason, as Superintendent of Guy's, said there must be an Education Committee to deal with matters pertaining to nurses' training, and Professor Pembury and other members of the Medical School gave lectures in Anatomy and Physiology and also served on the Committee. Professor Spurrell, returning to Guy's in 1933, readily agreed to lecture to student nurses and continued to do so until his retirement, which was typical of his love and service to Guy's.

All who knew Professor Spurrell will know of the importance he attached to understanding fundamental principles in the process of learning; he therefore elected to give lectures and demonstrations to nurses in the Preliminary and First Year Schools, examining nurses at the end of the Preliminary Course.

His command of the English Language and his ability to teach at the level of understanding of the students before him was such that the most difficult subject seemed simple and will be remembered by all who were fortunate enough to train at Guy's during these years. No doubt Professor Spurrell's greatest influence on Guy's nurses was through his continual interest and devoted service as a member of the Education Committee of the School of Nursing. He brought so much to these meetings—his University outlook, his ability to put aside problems of the moment which might cloud the horizon, his understanding that a well-planned, sound, balanced training would ultimately be for the benefit of the patient. This affected us all so that we were not only stimulated to aim at improving our plans and to change and adjust to present day problems, but also to keep in mind those basic principles of which he so often reminded us.

In his very busy life he could always find time to discuss problems with the tutors and help them to distinguish "the wood from the trees" and so present a solution with such clarity that we wondered why it had ever seemed a problem, but he never made one feel that his time had been wasted.

Surely, our greatest appreciation to Professor Spurrell would be that those concerned with Nurse Training and therefore patient care should keep his guiding principles in mind.

Yours, etc.,

M. G. BOURNE

Edgeley Crescent,
Station Road,
Whitchurch,
Shropshire.

SIR,—For a long time now I have sat in front of this square of paper gazing through it down a tunnel of years that ends at No. 5 and 6, Sandrock Road, Tunbridge Wells. The faint scent of rhododendron bushes is mingled with burnt cordite, the summer bird-song with the wail of the air-raid siren. The Guy's pre-clinical students, a vast bicycle club of would-be doctors and dental surgeons, were evacuated under a Kentish sky. A sky later to be lattice-worked by the vapour trails of the famous "Few."

As students we were privileged members of society. Privileged by exemption from conscription until qualified, and privileged in our hostels to gain small intimate insights into the characters of our tutors. Tutors who had taken over the noble task of Wardens of the hostels. It was as if the stage-actors had suddenly jumped into the close-up of the television screen. The lecture hall no longer divided them. To me the frame of that close-up screen was No. 5, Sandrock Road, whose Warden "The Doc" (now Prof. G. A. D. Haslewood), threw controversial verbal mills-bombs amongst us to make No. 5 a conversational volcano of mostly friendly, but always heated argument.

Over the road to us as Warden of No. 6 was Dr. Spurrell with his wife and family. To read in the *Gazette* of Professor W. R. Spurrell's death must, not only have saddened, but also sharpened his memory for many of his Tunbridge Wells students. Perhaps on their behalf I can say a simple "Thank You" to his memory. A "Thank You" for all we owe him as the rather austere teacher of the lecture-room, and the very human Warden of No. 6.

A very vivid scene is set in my mind as I write. Its characters are mostly hidden in the garden of No. 5. The rage of the film world at that time was the Wizard of Oz, and as students we had heard that the very young children of Dr. and Mrs. Spurrell had delighted in it. As students will, we decided to heighten their delight by making the film seemingly come true in the garden of No. 5. I was picked on to dress up as the Scarecrow, and stuffed with straw, sacking and make-up was propped against a pole in the garden. Everyone else hid and the idea was for two of the lads to collect the children from over the road and surprise them with the Scarecrow, who was slowly to come to life.

All went as planned, the children for a moment were in a fairyland, and the Scarecrow, with a child clutching each hand, was skipping and dancing down one of the garden paths singing "We are off to see the Wizard, the wonderful Wizard of Oz", when round the corner of a rhododendron bush we ran slap-bang into Dr. and Mrs. Spurrell. Apart from the embarrassment of being faced suddenly by such an illustrious audience, would the children's fairyland collapse? But not a bit of it, in spite of his surprise, Dr. Spurrell rose to the occasion. "Ah!" he said, " you must be the Scarecrow, we are looking for the Wizard of Oz, do you know where to find him?" This allowed our escape through the line from the film, " Follow the Yellow Brick Road", and off went the children and the Scarecrow again dancing round the garden singing " Follow, oh follow the Yellow Brick Road."

All the conspirators of the game, who were hidden in the bushes, were delighted that the make-believe had not collapsed.

Perhaps it is because I am standing in that garden again that I feel such a loss, for surely in Professor Spurrell's death a part of the youth of all those in the garden has gone with him.

In offering my condolences to his family, it is my belief that everyone lives on in all those who remember them with kindness. It must be a very large world that Professor W. R. Spurrell lives in to-day.

Yours, etc.,

B. WOOTTON.

14th July, 1966.
51a, Oxford Street,
Weston-super-Mare,
Somerset.

[*Apart from these two letters we also received an additional tribute to Professor Spurrell, which we would like to publish here.*]

Most of us on hearing the news of Professor Spurrell's death or reading his obituary recall personal experience of him which contributed to the awe and even reverence in which he was held. We think of him as the most fluent of lecturers; a little hard going for the student who reckoned to doze occasionally, for once the thread was lost, the intricate pattern of the lecture was lost also. We think of him wonderfully gifted at seeing into, and through, other people's work; he could grasp the problem and suggest ways of dealing with it in a brilliant fashion. His clarity of thought and his ability to find weaknesses in arguments, verbal or written, was remarkable and often devastating.

Many of us owe to him our positions today; he guided us as students, as post-graduates and as junior members of the staff. Of course, he did no research during most of his career, but who can point to a man with a greater understanding of his subject and to one more widely read in his subject? Most of us are hard pressed to keep up in our own small corner.

And so we held him in awe, and however much we might bluster in his absence, even the more irreverent of us fell under his spell when he appeared. We hung on his words, we memorised his more dramatic turns of phrase and if what we wrote was clear and concise we owed this to his guidance.

It would be dishonest to pretend that this human being was without human failings. Certainly weakness was not one of them, for his whole life exemplified courage in dealing with ill health, with difficult problems and difficult colleagues. What were his failings? Perhaps he was too detached, not emotional enough for some; he did not advance his department in step with the general expansion and modernisation of the medical school. This without doubt was a reflection of his personal modesty and his reluctance to see money spent on what he believed to be extravagance. If we disagreed with what he said or what he did, it was never because he was weak or dishonest; few of us will merit that verdict when our time comes.

Sir Rowan Boland

SIR, As many of your readers will know, it was decided last year to commission a portrait of Sir Rowan Boland, to be hung in the East Wing of Guy's House, probably in the hall leading to the dining room. The painter will be Miss Anna Zinkeisen.

We know that many people will wish to be associated with this project, and contributions should be sent to either of us. Cheques should be made payable to Guy's Hospital Medical School.

Yours, etc.,

R. J. CANN.
1st July, 1966. J. C. HOUSTON.

Room for the Relatives

SIR, You mention in the last issue of Passim the need for overnight accommodation for relatives of patients who are critically ill. This was foreseen when New Guy's House was planned and is provided in the rooms on most of the concourses of that building. It is available as necessary to relatives of patients elsewhere in the Hospital as well as in the surgical wards.

Yours, etc.,

A. H. BURFOOT.
Clerk to the Governors

11th July, 1966
Counting House,
Guy's Hospital,
London, S.E.1.

Where have all the Students Gone?

SIR,—Further to your recent "Passim" entitled " Where have all the students gone?" dealing with the subject of poor attendance at lectures, was it mere coincidence that at a recent Tuesday morning Surgical Pathology lecture given to a dozen or so students, the lecturer announced that this was to be his penultimate appearance? In addition to offering the explanation that thirty years was long enough for anyone to lecture, he also observed that the number of people attending the lectures had been diminishing especially of late, and he couldn't help feeling that this was a reflection of his lessening ability.

One of the arguments for making lecture attendance non-compulsory is that the numbers attending will directly reflect the standard of lecturing, thus supposedly encouraging that standard to be high. The discriminating lecture-goer chooses his speaker just as much, if not more so, than his subject; just as the concert-goer will be drawn by the conductor and composer and the theatre-goer by the director and author.

But in the case in point this is patently untrue. Here we are offered a man who not only has a vast experience in lecturing particularly, and communication of thoughts and ideas generally, but also is a world authority in his speciality. This is not all. It is unnecessary and presumptuous moreover, to go into the details of his lecturing technique. Suffice it to say that each one is a model of good lecturing to which it is a rare delight and a privilege to listen. But we don't go. There are to be no more. This is a tragedy. The loss and the fault is ours. I can't help but think that an inappropriate arrogance towards any suggestion of a need to attend, together with a misplaced and anachronistic sense of bravado at having not attended offers only a partial explanation.

If the lectures offered vary from the mediocre to the downright bad, we are correct to discourage them. But surely by the same argument and the same process of discrimination, if the lecture is first class, we should not only attend but applaud loud and long, and even more important pass on the good news to those who have either not read the time-table, or having read it, not realised what they have missed.

Yours faithfully,

CHRISTOPHER DAVIES.

14th July, 1966.
The College,
Guy's Hospital.

South African Promise

SIR,—There are two things that surprise me about Dr. D. Stafford-Clark's letter to the *Gazette*. The first is that being a man who is devoting his life to the challenge of disease, he should adopt such a pessimistic attitude to the prospect of reaching a just solution to the problem of multi-racialism in South Africa. The second is that he should feel so strongly about a subject of which he has had no personal experience except for knowledge obtained at a distance of six thousand miles. Of course, he is right to condemn unjust practices wherever in the world they may take place, but imprisonment without trial for suspected activities against the Government is so common-place behind the iron-curtain, that it passes without comment unless a British subject or author of international repute is the unfortunate victim. When the Government of South Africa, fearful of revolt, chaos and Communism, reacts in the same way, the facts are fully reported in the British Press because they are bound to get an emotional reception.

The problem in South Africa is enormous. Of the population of over 17 million, less than one person in five is white. Imagine a comparable situation in this country which restricts immigration from the West Indies to a mere trickle, where landladies turn away the coloured man and railwaymen persecute him.

The Bantu in South Africa is better off economically than is the native in any other part of Africa. If Dr. Stafford-Clark places more value on freedom from unjust laws and equal political status, I would like to assure him that there are very many white South Africans with just as great a humanitarian outlook whose views must in the end prevail. Therein lies the promise in "this land of sunshine", a promise that will be realised sooner by entry into it of enlightened men and women.

Yours, etc.,

T. L. T. LEWIS.

18th July.
109, Harley Street,
London, W.1.

Music Semi-Circle

SIR,—With all the recent talk of lack of liaison between the nursing population and the student body, may I bring to your attention the Music Circle. This was formed last April in order to fulfil what we thought was an existing need. Its purpose is to provide an opportunity for *anyone* connected with the hospital to discuss, listen to and make music.

The response for all ranks of the nursing staff has been admirable, but the student body hasn't shown the same degree of interest. In fact a recent meeting had an audience of 14 nurses and *no students.*

May we hope with E.M.I. putting on a demonstration next week (July 26th at 8 p.m.) in the East Wing Basement music room, that our audience may also include some students? Clearly if sufficient support isn't forthcoming, we shall just have to wind our activities up.

I do hope this isn't yet another abortive attempt to run a socially minded society. Please, support us to entertain *you*!

Yours, etc.,

HEDLEY BERRY.

2.7.'66.
East Wing,
Guy's Hospital, S.E.1.

We must apologise for a number of misprints in the Gazette of July the 9th. On page 349 the heading should have read Professor W. R. Spurrell. And in Mr. Cann's letter on page 350 the first sentence referring to House Jobs should have read " . . . have recently been under review . " instead of " . . . been made fewer"; and in the fourth paragraph of the same letter the first line should have read " . . . surgical firm" and not "surgical form" as we printed.

REVIEWS

EMBRYOLOGY.

M. B. L. Craigmyle, Bailliere, Tindall & Cassell, London, 1966. Pp. 208. *Price* 16*s*.

Any book which is a little more succinct and brief than the all too familiar over-weighty classics is worthy of inspection to-day, especially in the pre-clinical years, with a Second Professional Examination climbing steadily from two to three or even four separate subjects. Dr. Craigmyle's book is one of a new series, " Concise Medical Textbooks." This is planned to replace the well-known "Aids" series, and some of the illustrations in this particular volume appear to be derived from that source, though a large number are obviously new. It must be emphasized also that the text is entirely new, and that the author has clearly kept abreast of the most recent work. The text is lucid and pleasant reading, and the 86 figures provide an adequate level of illustration. Many students will prefer this to a larger text, but they should be warned that a proportionately higher percentage of its contents will be required of them. The book itself is commendably attractive in format and materials, considering its price. The copy reviewed did, however, contain a number of creased pages, defective registration of the print on the page at times, and the other small imperfections which we have come to accept as standard to-day. Since even the Encyclopaedia Brittanica is no stranger to such vagaries these days, this small volume compares most favourably in this regard.

PROFESSOR R. WARWICK.

CLINICAL CHEMICAL PATHOLOGY,

by C. H. Gray. 4th Edition. Published by Edward Arnold at 20*s*.

Students who have found it difficult to comprehend measurements made in units such as m. equivs., millimoles or K.A. Units during the 2nd M.B. course, may be alarmed to find them used so extensively in clinical medicine. This book presents the subject so concisely and in such an interesting manner that the aftermentioned students may have no further fears about the matter! The author does not pretend to cover the subject comprehensively, but all the important features are described. The clinical aspect of chemical findings are stressed throughout. The chapters on acid-base balance and fluid balance are particularly lucid, and the diagrams in the chapter on calcium and phosphorus sum up the disorders of bone metabolism in a nutshell. Questions on chemical pathology are asked with increasing frequency in Finals, and although medical textbooks state the chemical changes due to disease, they do not explain the mechanism of these alterations. This book fills in those gaps, readably.

JOHN CRISP.

ASIAN PEDIATRICS.

The Scientific Proceedings of The First All Asia Congress of Pediatrics, New Delhi, 1961. Edited by S. K. Bose and A. K. Dey, 476 pages, illustrated, £8, Published by Asia Publishing House, London, 1965.

The name of this book will mislead many readers. It is actually a report on the proceedings of the first All Asia Congress of Pediatrics held in New Delhi in January, 1961. Again the readers will not find the subject matter of the book wholly relating to the pediatrics practised in Asia, but it includes many papers read by workers from Africa, Australia, Europe, and America, who were attending the conference. Majority of the papers read were of general nature and did not relate to the diseases which are common in Asia. Some of the papers did not contain anything new that could not be found in the pediatric journals in the preceding few years. The fact that the book was published four years after the conference was held, has lessened the importance and the value of the book.

Some of the papers included in the book about the real pediatric problems of Asia and Africa are very useful and interesting. They have been prepared with a great deal of research work behind them. This will be appreciated by those who have some knowledge of the difficulties in conducting research work in that part of the world. It also gives an idea as to how the pediatric problems are being solved and what progress has been made in Asia.

The book covers all the general aspects of pediatrics, but the chapters on the Nutrition, Gastro-Intestinal Disorders, Infectious Disease and Social Pediatrics are most informative. It would make an interesting reading for those who hope to work in Asia and Africa. They can acquaint themselves with the problems that they would encounter there and of which they get no experience in this country.

This book, in spite of the delayed publication, can still be a useful work for reference about the region of the world about which little is reported in the pediatric journals, though the price of £8 may deter one from acquiring a copy of the book for their own collection.

M. I. SULEMAN.

REVIEW OF MEDICAL PHYSIOLOGY

By William F. Ganong. 610 pp. Blackwell. 2nd Edition. *Price* 52*s*. 6*d*.

This soft cover American textbook is up to date, reasonably priced and well produced. It has a number of merits that are worth mentioning. First its simple outline diagrams and drawings which go a long way to clarify the anatomy of the part discussed. Secondly, its concise and simple text written in two columns per page, with references at the end of most chapters. There is also a number of photostat reproductions of electronic graphs and of microscopic and macroscopic photographs which are very useful in some instances, although it must be admitted that a few are of slightly poor quality.

The whole book is logical, arranged in eight sections. An introduction on " physiologic " principles, followed by two sections on neuromuscular physiology endocrinology and metabolism, the remaining four sections being on gastro-intestinal function, circulation, respiration and the formation and excretion of urine.

If one can put up with Americanisms like "epinephrine", and prefer economy to "color", this book is well worth considering.

M. F. D'SOUZA.

PSYCHOANALYSIS AND BEHAVIOUR THERAPY IN THE TREATMENT OF NEUROSIS

by

D. I. Brough

Neuroses are now recognised as disorders of the pattern of thought, feeling and behaviour which develop during the life of the individual and tend progressivly to limit and disable the individual's capacity for normal existence[1].

Treatment of neurotic illness by psychoanalysis and behaviour therapy is widely practised both in this country and the United States. Much discussion has arisen concerning the indications and comparative efficacy of these two methods and much criticism has been directed by the advocates of one against the results achieved by the other.

The object here is to outline briefly the main considerations underlying treatment by psychoanalysis and behaviour therapy and then to consider the claims and criticisms advanced by each with reference to the literature.

Psychoanalysis may be said to rest essentially upon five points of view[2]. These may be termed respectively the topographical approach, libidinal development, the dynamic viewpoint, the law of conservation of energy as it relates to mental functioning, and finally the structural view. Each viewpoint is related to a large amount of speculation and observation which was constantly being added to and modified by Freud, the founder of psychoanalysis, throughout his life. Many psychotherapists utilise some of these viewpoints but only classical psychoanalysis uses all five. In this account psychoanalysis will be considered, mainly, but psycho-analytically orientated psychotherapy will also be mentioned.

The topographical approach assumes that the mind can be divided into three areas; the conscious, the preconscious and the unconscious. The second viewpoint states that current patterns of behaviour can only be understood in terms of past experience, and neurotic symptoms are manifestations of fixation of libido or regression to earlier development levels. The oral, anal, and phallic phases of libidinal development and the subsequent development of the oedipal situation, with corresponding conflicts and defences, are considered important in the classification of psychopathology.

The dynamic viewpoint sees all overt behaviour and conscious experience as the struggle between instinctive impulses trying to find expression, and the counterforces which operate to maintain self-control and esteem. The law of conservation of energy is held to relate directly to mental function; so that the more that is consumed in internal conflict, the less will be available to apply to external reality. Lastly, the structural point of view is a working formulation which refers to the inner reservoir of basic aggressive and sexual energies as the id: the apparatus of control and medication between internal needs and external reality as the ego: and the introjected parental and guiding social models as the superego.

Psychoanalysis usually involves analysand and analyst meeting five times weekly, and may last for several years. The object of psychoanalysis is to produce changes in the patient's ego by recreating and resolving infantile conflicts. The analyst sits behind the analysand and encourages him to say everything which occurs to him, including recounting dreams (free association). To begin with, the analyst takes a very passive role, encouraging the analysand to overcome any resistance to free association. Later the analyst begins to interpret the basic conflicts of the patient to give him insight, and the analysand attempts to shift to mature ways of handling life's experience. Finally, the transference situation is resolved and the analysis is terminated.

Many psychoanalysts believe that the method outlined above is the only treatment which will permanently resolve neurotic symptoms; and that all other methods, including those which make use of some of the psychoanalytical principles, are too superficial and at best will result in temporary alleviation of illness only[3]. Certain points, however, may be made at this stage which appear uncontestable. Cost, time, and availability rule out psychoanalysis as a feasible treatment to all save a tiny minority of patients and it is impossible to obtain psychoanalysis under the National Health Scheme. These are the main practical considerations, other theoretical criticisms of psychoanalysis will be mentioned later.

Behaviour therapy is a term used to describe a number of psychotherapeutic methods which have been developed in the past fifteen years. In contrast to the psychoanalyst many behaviour therapists have accepted a definition of neurotic behaviour as any "persistent habit of unadaptive behaviour acquired by learning in a physiological normal organism"[4]. Although a number of different techniques are used in treatment varying from aversion therapy to desensitisation, all have a common basis in the laws of learning which have been derived by experimental psychologists. As neurosis is regarded as acquired by learning, successful treatment can be carried out by techniques based on the laws of learning. In this context learning may be said to have occurred if a response has been evoked in temporal contiguity with a given memory stimulus and it is subsequently found that the stimulus can evoke the response although it could not have done so before[4].

Wolpe, one of the leading exponents of behaviour therapy, has stated that three issues required testing if any parallel was to be drawn between the production of experimental neurosis in animals and the

occurrence of neurotic symptoms, as defined above, in humans. These were, that the maladapted behaviour was acquired by learning; that there would be a spread from the central stimulus according to the principle of primary stimulus generalisation; and that unlearning of the maladapted behaviour could occur by extinction or inhibition.

A brief case history may be used to illustrate these three points :

A woman aged 42, previously well, had a very frightening (anxiety) experience with wasps (conditioning stimulus). She subsequently became afraid (anxiety) of bees, moths and pigeons (stimulus generalisation). She was able to make a list of these stimulis according to the amount of anxiety which they produced—formulation of hierarchy as described by Wolpe. Finally, by presenting the least anxious of the stimuli first, in circumstances where anxiety was inhibited (in this case by presenting the stimuli ideationally whilst the patient was relaxed under light hypnosis), this patient's phobia was relieved by the behavioural method which Wolpe calls reciprocal inhibition.

Wolpe, in studying the historical antecedents of the symptoms in a large number of cases of neurosis, found that most patients could relate the onset of their symptoms to one clear distressing incident. Stimulus generalisation he elicited by careful history taking. Finally he found that following the formation of hierarchies, maladjusted behaviour would be reversed by a number of different techniques involving reciprocal inhibition.

The general areas of controversy between these two methods of treating neurosis may now be briefly stated. Some psychoanalysts insist that their method is the only one available which will permanently enable a patient to deal with his neurotic symptoms and that all other methods including behaviour therapy will result only in temporary amelioration of symptom substitution[5]. The results of many follow-up studies which were designed to elucidate these points are now available[6 and 7]. Many behaviour therapists regard their methods as being the only ones available which are scientific in contrast to psychoanalysis which they regard as being based upon experimentally untestable speculation[8]. Behaviour therapists argue that the resolution of "deep seated conflicts", even if they exist (which they do not accept as proved), is unnecessary to produce permanent improvement in neurosis. They claim that their methods, scientifically based, offer permanent cure at considerably less cost in both time and money to the patient. Opponents of behaviour therapy, however, contend that these results are achieved by the degree of rapport, or the enthusiasm of the therapist and not primarily with the behaviour technique used. This endless and often emotionally charged controversy continues.

In attempting to come to some provisional conclusions concerning these controversies a few preliminary observations may be made. It has been pointed out that there is a forty to sixty per cent recovery in untreated patients with neurosis and this must be taken into account when considering the efficacy of any treatment[9].

Furthermore, a direct comparison between these two methods which would satisfy statistical requirements would be difficult, and anyway has so far not been done. Many shortened forms of psycho-

therapy based on psychoanalytical principles are practised by psychiatrists, but unfortunately, objective evidence of results for comparison with other methods is meagre. Clinical experience, however, suggests that these psychoanalytically orientated therapies are highly successful in many cases.

Many carefully controlled trials of behaviour therapy have been done which have been designed to show that the behavioural techniques used has been the important factor in obtaining improvement. In summary, it would appear that improvement is not dependent upon patient-therapist relationship, suggestibility, or relaxation techniques, and that in the follow-up studies maintenance of improvement is striking and there is little evidence of symptom substitution. It is also apparent that earlier claims of a ninety per cent remission rate in all neurosis[10] treated by behaviour therapy, has not been widely substantiated, and more attention is now being paid to the indications for selection of patients for behaviour therapy. For example, there is very little doubt that systematic desensitisation under light hypnosis is extremely effective in the treatment of monosymptomatic phobic anxiety states particularly where the phobia is having a major effect upon the life of the patient[11], e.g., inability to travel; and that symptom substitution or relapse is rare. On the other hand, patients with multiple phobias and with marked interpersonal difficulties may require interpretive and insight therapy in addition to behaviour therapy.

In conclusion, therefore, it may be stated that psychoanalysis, psychoanalytically orientated therapy, and behaviour therapy, have all been used with considerable success in the treatment of neurosis. Many of the criticisms by one of the other have proved to be unfounded. It would appear that attention should be directed towards working out which patients are likely to benefit from which form of treatment, and it may be that the most effective therapy may turn out to be a combination of both.

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NURSING SECTION

Definition of a Nurse

On a recent Registrar's ward round, it was noticed that the record of the respiration rate on a certain temperature chart was filled in for the following day, but that the apex beat had not been entered for that morning! This is amusing up to a point and proves that nurses are only human after all. However, it serves to illustrate the fact that these mistakes are sometimes found. These errors and inaccuracies may well be due to carelessness on the part of the nurse concerned, but more often than not, are due entirely to the pressure of work.

It appears to be the increasing lot of the nurses to be used as technicians to record facts and observations which are becoming more complex and in greater quantity, and are not, strictly speaking, the work of a nurse.

The definition of a "Nurse" is now being radically changed. Virginia Henderson once wrote—" The nurse's unique function was to help the individual to do those things that he would for himself, had he the strength, will or knowledge, that would lead to his recovery or his peaceful death."

Surely this quotation applies in greater degree now than it ever used to, with the average life expectation and the number of hospital patients greater than it has ever been.

The purely domestic tasks of nurses have been relieved and the work aided by science and mechanisation. The basic care, however, remains the same, but more is being expected of the nurse. Certainly her knowledge is advanced and she is more scientifically minded than she was even a decade ago. In spite of this she should not be used as a research worker, and if medical research goes on, as indeed it must, then research records and investigations will have to be carried out by others.

It is now obvious that all non-essential, non-nursing tasks at present carried out by nurses will have to be curtailed and pure nursing relating to the comfort and well-being of the patient remain the prime consideration of all those who enter this profession.

Changes in the Nurses' Home

For the next few weeks it will become obvious that at meal-times the nurses disappear underground like rabbits and emerge three quarters-of-an-hour later—well fed! This is not due to an inborn desire to burrow, but to the fact that the front hall of the Henrietta Raphael Nurses' Home is now closed for structural alterations. Entry is now gained either by the back door or the underground passages.

It was stated in the last issue of the Gazette, in the deaths column, that Miss Alice Maud May Park, S.R.N., S.C.M., I.S.T.M., died on the 26th May, 1966. In fact, Miss Park died on the 26th June, 1966.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

S/N G. Green (née Jenkins), to Surgical X-ray.
S/N J. Hunt, to Dental Outpatients Department.

PROMOTION

C/N S. Bailey, to Sister on Night Duty.

DEPARTURES

Sister D. Chrimes, from Outpatients Department.
Sister N. Morris, from Casualty.
S/N A. B. Brice, from Lydia Ward.
S/N P. Homer, from Addison Ward.
S/N B. C.. Hooker, from Casualty.
S/N A. J. Owen, from Cornelius Ward.
S/N E. Pickstock from Night Duty..

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SPORT

This week is notable only for the fact that Guy's had scored against them the largest opening stand in recent years, possibly ever. In a new fixture against Metropolitan Police, Guy's put their opponents in on a grassy wicket, which one might have expected to help the bowlers. This was not to be, and against a rather weak attack, the Police declared at 245 for 0!!! In mitigation, it must be said that half the team had been at the Grosvenor House the previous evening, enjoying a most excellent Matron's Ball. Fortunately, the batting performance exceeded the bowling performance, and Guy's crept in with a draw, being 164 for 9 at the close.

In another new fixture in the middle of the week, Guy's easily beat the North of Ireland by about 100 runs. Guy's just managed to creep in against the Nomads. Nomads were all out for 230, and Guy's were 60 short with one wicket left when stumps were drawn. In the other game in the past fortnight, Streatham beat Guy's by two wickets. Reports of these three games follow.

The tennis team have had unfortunate luck with rain. They had to stop when losing 4—3 to Shooter's Hill, who had beaten Guy's 9—0 early in the season, and then, on the tour to Hampshire, had the fixture against Winchester cancelled. In the other match, on the tour, they lost 5—4 to West Hants. in Bournemouth. However, they did manage to slip into the final of the Hospital's Cup by thrashing the Middlesex 9—0, and so defend the cup in the near future.

In the year in which his neighbours are making such a victorious tour of England, Jo Butchey, from Guyana, seems determined to share in their success. Already this season he scored nearly a thousand runs, including two centuries, and has an average of over 50.

Tom Chick has many harrassing moments as groundsman at Honor Oak Park, but none so harrassing as when he found eight young ladies in earnest practice in the nets. He was quickly on to the 'phone to Mr. Silk, who informed him they were nurses practising for the annual match against the students. Your correspondent rushed up to H.O.P. to study the form, but was allowed only a short preview before being bundled off. However, one was seen to be working up terrific pace off a 27 yard run.

The tour to Sussex starts on 29th July, but due to Mr. Lewis being indisposed, it is doubtful whether the team will be staying at Thatchings. Anybody who has been on a tour will know how important this is to the success of the tour, and one hopes an adequate substitute can be found and wishes Mr. Lewis a rapid recovery.

DIARY

CRICKET:

July:	Fri., 29th—Basingstoke.	Tour
	Sat., 30th—Littlehampton.	
	Sun., 31st—Bognor.	
Aug.:	Mon., 1st—Ferring.	
	Thurs., 4th—Cuckfield.	

TENNIS:

July: Sat., 23rd—Barts.

REPORTS & RESULTS

CRICKET

GUY'S v. MAYFAIR

At H.O.P. Sunday, 3rd July, 1966

Result: won by 7 wickets

Guy's won the toss and decided to field on a green looking wicket. This decision was vindicated when Clark and Beacham had sent both openers back to the pavilion with only three runs on the board. Some confident but slow

middle order batting enabled Mayfair to reach 134 for 8; Davoodbhoy bowling well, taking 4 for 49. Clark was then brought on; bowled the last two batsmen; brought his analysis to 4 for 44, and Mayfair's final total to 164.

After tea there followed one of the biggest onslaughts of a bowling attack seen this season. Butchey and Gillham put on 110 for the first wicket when Gillham was caught behind for 24, Butchey meanwhile reaching his 50 in only 35 minutes, with a succession of viscious hooks and pulls. After 75 minutes he reached his second century of the season. After he had holed out, Silk and Clark saw Guy's safely home, Guy's winning by seven wickets with half-an-hour to spare.

D. B. A. SILK

GUY'S v. NORTH OF IRELAND

At H.O.P. Tuesday, 12th July, 1966

Result: won by 96 runs

Guy's were put into bat by an opposition of unknown quantity. Butchey and Thomson started briskly until at 19 Thomson was l.b.w. for 10. Crafts and Butchey moved the score along steadily to 50 until the former was out in the same way. Silk followed soon afterwards. Griffiths consolidated the middle order batting, and was well supported by Appleby, Carruthers and Rowlands, and Guy's were able to declare with 200 on the board.

Through lack of bowling strength in the Guy's side, Appleby was handed the new ball for the first time in his life. The sniggering in the field soon stopped when in his second over he trapped the No. 2 batsman l.b.w. when there were only five runs on the board. He continued to bowl well, moving the ball off the pitch and bowling to a field that would do credit to many opening bowlers. After dismissing the first three batsmen, Davoodbhoy and Crafts were brought on. Both bowled well, the former taking two wickets, the latter three. Appleby was brought back on and bowled the last two batsmen to bring his figures to 5 for 38 in 21 overs, and the North of Ireland's final score to 104. It should be mentioned that the fielding was of a very high standard, much enthusiasm being showed by everyone, notably by our two 2nd XI guests.

Guy's: 200 for 9 dec. (Griffiths, 50.)

North of Ireland: 104. (Appleby, 5 for 38; Crafts, 3 for 16.)

D. B. A. SILK

GUY'S v. METROPOLITAN POLICE

At H.O.P. Saturday, 16th July, 1966

Result: draw

Guy's put the Police into bat, and opened the bowling with Clark and Appleby, the latter fresh from his success against North of Ireland. He did not, however, bowl up to expectations and was taken off after only two overs. He was replaced by Turfitt, who with Clarke bowled steadily, getting no help from the wicket and not troubling either batsmen. In the first hour, the score was 105 without loss. Butchey and Steer replaced the two seamers without success, both being unable to find a length, and as a result proving expensive. Pearson was put on with a combination of Clark and Turfitt at the other end. All three bowled steadily but were totally unable to get through either opening batsmen. Reeve scored 161 and Oriel 73 at the close, when they were able to declare with the score at 245 without loss. With all due credit they batted very well, and their running between wickets was a fine example to all of us. With the absence of Beacham we bowled badly; everyone lacking the drive and determination that we saw against North of Ireland.

Guy's, chasing this big total, were given a fine start by Gillham and Butchey: Gillham scoring a fine 37, until with the score at 58 he was caught in the slips. A fine stand by Clark and Butchey saw the 100 up for the loss of only two wickets. After Butchey was out, there followed a procession, until it became imperative that Pearson and Turfitt should save the game by surviving two overs. Long odds were quoted against it, but they survived and Guy's were able rather ingloriously to draw.

Met. Police: 245 for 0 dec. (M. Oriel, 73 n.o.; J. Reeve, 161 n.o.)

Guy's: 164 for 9. (J. Butchey, 44; R. Clark, 40.)

D. B. A. SILK

GUY'S v. STREATHAM

Away. Sunday, 10th July, 1966

Result: lost by 2 wickets

Guy's: 153. (Butchey, 56; Crafts, 36 n.o.)
Streatham: 154 for 8.

Guy's elected to bat on a wicket that looked full of runs; unfortunately, a rather undistinguished and lethargic batting display followed. Only Butchey and Griffiths of the early batsmen offered much resistance to some steady though hardly penetrating seam bowling; Butchey completed a sound 50. After losing nine wickets for 122, there followed, in the best Guy's tradition, an undefeated last wicket stand of 31 by Crafts and Beacham. The former showed all his old professional polish in a fine innings of 36.

Against same wayward opening bowling, Streatham made a bright start, and were immediately put ahead of the clock. Guy's were handicapped in having to field in a steady drizzle, which was particularly troublesome to our spin attack. Streatham took advantage of some loose bowling by Appleby to put the issue beyond doubt, though Crafts and Beacham with accurate second spells gave the scoreboard a healthier look. Streatham eventually won by two wickets with 15 minutes to spare.

M. APPLEBY

GUY'S v. THE NOMADS

At H.O.P. Saturday, 9th July, 1966

Result: drawn

Nomads: 230. (Hewett, 126.) (Davoodbhoy, 5 for 79; Steer, 4 for 71.).

Guy's: 173 for 9. (Clark, 71; Gillham, 32.)

The Nomads had first use of a good batting wicket. By lunch their opening pair had put on 130; in doing this they had been helped by a considerable amount of luck and some generous fielding errors. After the break the attack was placed in the hands of Steer and Davoodbhoy, and they proceeded to dismiss the opposition for 230 after the first wicket stand had been carried to 154; a fine performance by both bowlers.

It appeared that Guy's had been left sufficient time to make the runs. After Butchey—a very rare failure, this—and Thomson had been dismissed with the score at 13, Gillham and Clark shared a partnership of 101. The latter played particularly well, and it needed a catch by a Guy's man representing the opposition to dismiss him. After Clark had gone, Guy's became further and further behind the clock, though the manner in which some of the batsmen were dismissed might have suggested that victory was just round the corner! It needed a defiant last-wicket stand of 10 minutes to save the game. Guy's should never have been in danger of losing. One last remark, requiring no further comment, I imagine: Guy's bowled 68 overs to the Nomads' 42.

M. APPLEBY

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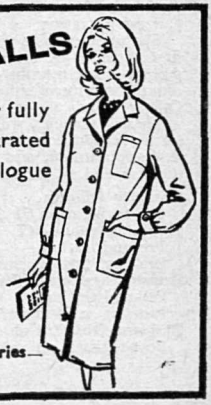

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL, S.E.1.

Applications are invited for the post of **Lecturer in the Department of Surgery,** with duties commencing 1st October, 1966, and appointment for one year in the first instance. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be returned not later than **31st July, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Registrar in the Dental Casualty Department,** to attend on six sessions per week, with duties commencing 1st October, 1966. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Thursday, 4th August, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Registrar in the Department of Preventive Dentistry,** to attend on three sessions per week, with duties commencing 1st October, 1966. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Thursday, 4th August, 1966.**

GUY'S HOSPITAL

HOUSE APPOINTMENTS

September 1st, 1966

Applications are invited for the following House Appointments at Guy's Hospital, due to begin on September 1st, 1966, applications giving choice of post and choice of hospital, in order of preference, to be lodged with the Superintendent, not later than **July 29th, 1966.**

Assistant House Surgeons
Pre-registration 4

The appointment will be for six months, the first three to be spent as A.H.S. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Surgical) or will remain as A.H.S.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Assistant House Physicians
Pre-registration 5

The appointment will be for six months, the first three to be spent as A.H.P. During the second three months of the appointment candidates will move either to the post of Casualty Officer (Medical) or will remain as A.H.P.

These vacancies will normally be open only to pre-registration candidates applying for their first appointment and not to candidates seeking their second six months appointment.

Casualty Officers
Pre-registration 6
House Surgeons (2)
Pre-registration 1
Pre- or post-registration 1
House Physicians (2)
Pre-registration 1
Pre- or post-registration 1
Resident Obstetrician
Post-registration 1
Gynaecological House Surgeon
Pre- or post-registration 1
Throat and Ear House Surgeon
Pre- or post-registration 1
Neurological House Physician
Post-registration 1
Orthopaedic House Surgeon
Pre-registration 1
Dermatological House Physician
Post-registration 1
House Surgeon to the Thoracic Unit
S.H.O. 1
Children's House Physician
Pre-registration (2nd six months) or post-registration 1
House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Pre-registration 1
House Physicians in the Department of Psychological Medicine
S.H.O. 2
(To commence 1.10.66)
R.M.O. Nuffield House
S.H.O. 1
Resident Anaesthetists
S.H.O. 2
Children's House Physician at the Evelina Hospital
Post-registration 1
(To commence 1.10.66)
Casualty Officer at the Evelina Hospital
Part-time (six mornings per week) from 1.10.66 1

ST. OLAVE'S HOSPITAL
Casualty Officer
S.H.O. 1
Gynaecological House Surgeon
S.H.O. 1

NEW CROSS HOSPITAL
House Physician in General Medicine and Geriatrics
Pre-registration 1

The Medical Committee will also consider applications for appointments at outer hospitals as follows:—

BECKENHAM HOSPITAL
House Surgeon
Pre-registration 1

HITHER GREEN HOSPITAL
House Physician in General Medicine and Infectious Diseases
Pre-registration 1

JOYCE GREEN HOSPITAL
House Surgeons
Pre-registration 2
House Physician
Pre-registration 1

LEWISHAM HOSPITAL
House Surgeon to Mr. Le Brun
Pre-registration 1
(Locum from mid-August to September 2nd)
House Physician to Dr. Gans and Dr. Llewellyn Smith
Pre-registration 1
(Locum from September 1st to 15th)

PEMBURY HOSPITAL
House Surgeon
Pre-registration 1

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's, therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts is available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectively. A candidate who has completed his first six months in a specialty (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

R. J. CANN,
Acting Superintendent

July 4th, 1966.

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PAPERS BY GUY'S MEN

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ENGAGEMENT

The engagement has been announced in New York between Lieutenant George Taft (U.S.N.), Washington D.C., and Miss Christine Lila Lane, S.R.N., S.C.M. (1955-59).

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2035

GUY'S HOSPITAL GAZETTE

PASSIM

Abortion Bill

The very elemental procedure of abortion understandably arouses the full purple-to-red spectrum of emotional reaction, seen extremely clearly in the Commons debate on the subject a fortnight ago. Once again the pressures of social living forced their way into the attentions of the lawmakers. Once again those who spectated were impressed with the highly partial, emotional and dysfactual manner in which such matters were dealt with by their parliamentary representatives. The debate was widely praised as it was an opportunity for party doctrinaire adherence to be replaced by individual personal bias.

The medical profession is inevitably involved in matters like abortion which for better or worse are controlled by parliamentary rather than individual conscience. That such a bill could come forward and its predetermined opponents be heavily defeated by the vote was perhaps inevitable, exemplifying the classic sequence of law-making following some way behind social custom. For without doubt the custom is well established particularly amongst those who have the right connections and money. Where the medical profession becomes restricted or guided, depending upon the viewpoint, by the law of the land it usually finds a way of going about things as and when it and the patient see fit.

In these and future days of preventive medicine wherein medicine ventures further away from the laboratory and ward into the home and environment of the patient, the involvement of the doctor inevitably increases in scope. The degree to which the doctor within the bounds of professional secrecy may feel himself free to treat his patient independently of the opinions of others, whether medical or not, is a long-standing problem within which each doctor will act according to his conscience and medical opinion. The consultation is an intensely personal and private exchange between two people concerning a matter of health in its widest W.H.O. definition, and those outside this immediate exchange must recognise the limitation of any pressures they might wish to bring upon such an exchange.

Whatever the law it will, in need, be broken. If it is easily broken it serves little practical purpose except to preclude those less financially, emotionally or intellectually fortunate enough to loophole it. If we may be presumptuous enough to advise parliament—and from the debate it was clear that it was in need of advice—it has its example in the Wolfenden Report and the laws which followed. Vice and amorality, as considered by only a portion of society, however large, exists and will. The ultimate purpose may well be better served by joining and controlling than by fruitless attempts at beating and abolishing.

Nursing Crisis

Recently, owing to a shortage in qualified nursing staff, there has been a curtailment of the intake into New Guy's House by the closing of two beds on each surgical ward and in addition, because of similar difficulties in theatres, all surgical firms have been requested to keep their lists down to a minimum.

This is a very unfortunate and disappointing thing to occur at such a widely reputed hospital as Guy's, and we are intending to publish in the next *Gazette* some explanation from Matron's Office as to why this has come about. Whatever the reasons, however, it is to be hoped that the situation will be remedied as soon as possible and that the Guy's nursing service, which is second to none in the world, will be restored to its full strength and efficiency.

Some way by which the problems can be solved is printed in this issue in a short article on Ward Receptionists on page 401.

Professor Atkins President

All Guy's men are delighted to learn of Professor Hedley Atkins' recent election to the presidency of the Royal College of Surgeons in succession to Lord Brock. This is only the second time in history that a hospital has been so honoured as to have two successive presidents to the college and the last time this occurred it was under very different circumstances.

We are sure everyone would join in in extending to the Professor our warmest congratulations; our only regret is that his new duties will deprive us of some of his time.

Mr. Blaikley

Mr. Blaikley has been Superintendent of Guy's for eight years, and he has hitherto found time for the ever-increasing administrative duties involved, in addition to the calls on his busy clinical life. He has now resigned from the appointment of Superintendent so that he will be able to take up full clinical duties again. Everyone at Guy's is delighted to see him working again and taking his accustomed place in the care of his patients.

MR. FREDERICK COULSON

Mr. Frederick Coulson died recently on Job Ward, after having served the hospital for over twenty years in the hospital telephone exchange. He built this department up to such a high degree of efficiency that it even received comment in the national press. We offer our sincerest condolences to his relatives.

Obiter Dicta

Mr. D. N. Ross, commenting on a recent operation: "The heart's a bloody funny thing."

PSYCHIATRY AND GUY'S HOSPITAL*

by
Dr. David Stafford-Clark

It is sometimes said that Guy's is a surgeon's hospital—whatever that may mean. Certainly the traditions of practical surgery, of skilful, wise and adroit surgeons, and their significant contributions to the running of the hospital, as well as the performance of their own special clinical skill, have long been prominent among the traditions of Guy's, and happily remain so. But most of us, asked to reel off the names of famous Guy's men of the past, might well find more names of physicians than of surgeons springing to our minds; Bright, Gull, Hodgkin, Hurst and Wilks are commemorated by the titling of Wards, whereas surgery can claim only Astley Cooper. Sarah Swift, midwife, and therefore acquainted with the medical arts of obstetrics, as well as their surgical expression and further developments in gynaecology, stands as it were on neutral ground. The physicians have recently received reinforcement by the addition of the names of the four consultants in psychological medicine, who preceded those still living as past or present members of the staff: those four being, in historical order, John Dickson, George Savage, Maurice Craig and Robert Gillespie. Their names have been given to each of the four wards of the York Clinic, which were previously known only by a number related to their height from the ground.

In this kind of name counting, there is always an implication of conflict; and few pursuits are likely to be more wasteful of effort and goodwill, or more destructive of practical co-operation, than a divisive or schismatic approach to the activities of a great society—which in one way is just what Guy's Hospital is, and has always been.

Let us then say rather that Guy's is essentially a practical hospital, and Guy's sons and daughters are taught to be practical people. This, unlike the observation quoted in my opening sentence, is no rash generalisation. Perhaps it would be graceful as well as just to quote an eighteenth century Guy's surgeon in support of this view of the ultimate aims and endeavours of his hospital:

> "A hospital is not only an instrument of relief to the distressed who are immediately helped there, but also a means of helping others, . . ."

This is part of a quotation which appears at the beginning of many numbers of the Guy's Hospital Reports, and is taken from the writings of Joseph Warner, Surgeon to Guy's from 1745—1801[1].

Another famous Guy's man, a physician whose name we have already encountered, Richard Bright, also appears in this important context from time to time:

*This is the concluding article of our psychiatric series.

"It is my wish in thus recording a number of cases, to render the labours of a large Hospital more permanently useful, by bringing together such facts as seem to throw light upon each other."[2]

It is perhaps a happy accident, or possibly a particularly elegant and just exercise of editorial balance, that in the two special numbers of the Guy's Hospital Reports which have been devoted to psychiatry[1, 2], Mr. Warner's words preface the first and Dr. Bright's the second.

Psychiatry at Guy's Hospital has a tradition which goes back even further than either of them. Indeed, the founder himself introduced the concept of psychiatric care in a general hospital in the terms of the will by which he made the bequest which led to the foundation of the hospital in 1724. The hospital opened a year later with accommodation for 435 patients, of whom 20 were lunatics; a term now obsolete, but linked in the founder's mind with his basic intention that his hospital should receive "400 poor persons or upwards labouring under any distempers, infirmities or disorders thought capable of relief by Physic or Surgery; but who by reason of the small hopes there may be of their cure, or the length of time which for that purpose may be required or thought necessary, are or may be adjudged or called incurable . . . ."[3].

The history of psychiatry at Guy's Hospital was reviewed in two consecutive essays, with this title, opening the two special numbers of the Guy's reports referred to above. It has also featured in a number of the series of special articles commissioned by the Editors of the *Gazette,* which I have been asked to conclude.

My title for this final contribution to the present series, which needless to say I have been delighted to welcome, is only slightly but significantly different. Psychiatry *and* Guy's Hospital is the theme which I shall briefly develop, partaking not so much of the past, but of the present, and even more of what may be our reasonable aims and intentions for the future.

When I was a medical student at this hospital, the present in terms of my experience at that time was very different from what it is now, not least in the field of psychological medicine. Notwithstanding the fact that the physician then in charge of the Department of Psychological Medicine was Robert Dick Gillespie, a man with international reputation, and co-author with the late Sir David Henderson of what was at that time perhaps deservedly the most famous textbook of psychiatry in the English language[4], we Guy's students had very little opportunity of learning the practical implications of Gillespie's subject in our own hospital. Gillespie had only five beds, each one of them in a different ward. There was no undergraduate psychiatric appointment, although it was possible, between completing one's clinical appointment and seeking or obtaining a house job, to do an elective appointment involving attendance at Dr. Gillespie's out-patients. By the time I came to Guy's he had founded the first children's psychiatric clinic to be held at a teaching hospital; but of all the remarkable achievements of this shy, gentle, gifted, and kindly man, perhaps that which history will judge to have

been the most significant was his selection of Guy's for the founding of the first in-patient psychiatric unit ever to be embodied in a teaching hospital in the United Kingdom. Gillespie did not live to enjoy even the first fruits of this break-through in clinical teaching for which he had laboured so long.

The Clinic was built and opened during World War II, and before it became available for peacetime use, Gillespie was dead. But central to his hopes for this pioneer development, and always close to his heart, was the idea that medical students should have as ready access to patients suffering from predominantly psychiatric disorders as they already had to patients in the general medical and surgical wards of the hospital. He hoped, too, that the York Clinic would attract a senior and junior staff who should give and gain from constant intercourse with colleagues in all other branches of medicine and surgery. In the memorandum in which he expressed these hopes, he embodied them, with characteristic humility, in a memorable but perhaps little known quotation from the Book of Proverbs, which perfectly accords with the sentiments of both Joseph Warner and Richard Bright:

> "Iron sharpeneth iron; so a man sharpeneth the countenance of his friend."[5]

So it is now possible for the student at Guy's to add to his knowledge of surgery, with its natural emphasis on the mechanical aspects of structure and function of the human body, and medicine, with its concern with the operational aspects of these things, an acquaintance with that branch of medicine traditionally called psychological medicine at Guy's, but now much more widely known as psychiatry, whose essential concern is experiental and subjective developments of the human condition. Of course, all these aspects and elements overlap: but no Guy's student now can qualify without having at least encountered ". . . that most human aspect of human beings, their awareness of themselves, and their capacity to communicate with each other. . . ."[6]

That iron has sharpened iron, as Gillespie hoped, is proved by our current acknowledgement of the relative incidence and importance of the psychiatric component in human suffering. Before the York Clinic had been completed, Sir John Conybeare (then Dr. J. J. Conybeare) had not only embodied a lucid and succinct section on psychological medicine in his world-famous textbook[7], but had expressed the opinion that between twenty and thirty per cent of all patients seen at out-patients required some degree of psychiatric understanding for their complete assessment, diagnosis, and treatment. Later editions of his book quoted the estimate of the B.M.A. Committee on Mental Health[8] that psychiatric disorders might well account for 30 per cent of all sickness in the population.

Recently our present acting-Superintendent, former Chairman of the Medical Committee, and one of the best-loved men at Guy's, Mr. R. J. Cann, remarked that he had long taught his students that the work they would encounter in his Department could be divided roughly into "30 per cent medicine, 30 per cent surgery, and 30 per cent psychological disorder. . . ." Few would venture to disagree with his experience. But what about the 10 per cent who, by impli-

cation at least, remain outside these three categories, which do not vary very much in any special or general branch of medicine or surgery. These I think are the 10 per cent of all out-patients who are seeking something which they may truly and deeply need, but which may not be within the province of medicine or surgery wholly to provide.

At the present time such people, even more than the 30 per cent for whom psychiatry may have a specific role to fulfil, tend in the end to come the way of the psychiatrist, at least so long as they remain patients at all. A thoughtful letter, written by a general practitioner after a recent post-graduate course run for such doctors at Guy's, and dealing with his reflections on the course after returning to his practice, ran as follows: "I think it was very helpful to understand how important, and how real the illness of depression can be; and to learn how to recognise it, and something of the ways in which it may be treated. Nevertheless, I am still left wondering whether some of the people who come to consult me are not so much depressed in the sense of suffering from depression, as simply unhappy—unhappy about their lives, their wives, or their husbands, their children, their friends, or their job—or the lack of these things. And what is the general practitioner to do about them?" What indeed? Perhaps his most important contribution here is to recognise the nature of the problem in his particular role as a perpetual student of the human predicament, and to bring to it at least that imagination and compassion which are the beginning of wisdom.

I have made my own humble attempt to address myself to this aspect of medicine in the epilogue in my textbook[6]: if I had not already published it, it might have formed the nub of this article. but when I yielded to the persuasions of the *Gazette* to conclude this series with a personal essay, I determined to resist the temptation either to paraphrase or reproduce the essence of what I had already publicly said or written so many times, and in so many other places.

I see this contribution not so much as ending the series, but as an occasion for considering questions raised or answered in preceding articles. The most important question is what will be the practical tasks of psychiatry in the future work of this hospital and medical school. As we have seen, there is in Guy's a traditional involvement with psychiatry. Yet the course of this involvement has been uneven. For while in a sense it would be true to say that provision for the care of the mentally ill was one of the primary considerations actuating the founder of this hospital, from the moment of its foundation, it would be necessary to add that such services, although nobly begun and well continued for some time, came to be regarded with increasing embarrassment and distaste by many members of the hospital staff in later years, so that by 1859, Guy's Hospital had ceased to make a special and noteworthy contribution to this aspect of medicine which had been so clearly intended by its founder.

The wards, then closed, were adapted for other patients, and immediately re-opened as Miriam and John. It is not without irony that only ten years after these wards were closed and the patients discharged to other hospitals, the first course of lectures and demon-

strations in mental diseases was given by John Dickson in the summer time of 1869, as described in one of the preceding articles by Dr. Fleminger[9]. For over a century and a quarter, from 1725 to 1859, Guy's had maintained between 20 and 25 beds for psychiatric patients in a total bed complement of 435: one century later still, when the York Clinic had been opened for over 10 years, the total number of beds at Guy's was 832, of which the York Clinic accounted for 45. The proportion remained almost the same. This is something which, without laying ourselves open to the charge of simple empire building, we shall certainly need to change in the future.

The proportion of psychiatric beds to the total number of beds in a teaching hospital cannot reasonably be less than 10 per cent. Many would contend that it ought to be higher, and certainly it would have to be higher if the teaching hospital by itself were to endeavour to fulfil the other role which it has recently assumed, that of a responsible contributor to the district hospital service. But as I put forward in a memorandum[10] commissioned by the Association of Teachers of Psychiatry in Undergraduate hospitals, subsequently submitted also on behalf of the Royal Medico Psychological Association and the Psychological Medicine Sub-Committee of the Royal College of Physicians, the reasons for suggesting that hospitals of the the general size of Guy's need at least 80 psychiatric beds of their own, in addition to any facilities which may be available to them at associated hospitals, are that a teaching hospital has certain services to perform both for the clinical care of those particularly dependent upon it, and for the instruction of those who come to it to learn their job.

These services can be conveniently classified under four separate but overlapping headings :

1. Undergraduate teaching with the primary object of introducing the student to the realities of the relationship between mind and body in human beings generally, and in medicine in particular. Postgraduate teaching to selected candidates following qualification to join the stream of those ultimately responsible for raising the level of community care in this field.
2. Such a unit has an obligation to assist the parent hospital in consuming its own psychiatric smoke. This means that the unit must be prepared to accept all acute psychiatric disorders arising either within the other general and special medical and surgical wards of the hospital, or among the staff or their relations. In practice, in fact, this service inevitably has to be expanded to the care of former students and their families, and indeed all those persons associated with the life of the hospital as a whole. Such patients form one category of those listed under the general heading of special referrals which will be considered later on in this memorandum.
3. The normal contribution of service to the community as a whole; requiring the provision of beds for psychiatric services

offered to out-patients, emergency and special referrals to the unit from the wider community and indeed from the world.

4. The function of fostering and undertaking research, and indeed of being able to think about the subject and its integration with medicine and surgery as a whole, remains a paramount responsibility of such a unit.

The implications of these needs in practice can be readily calculated in the case of each of the four functions outlined above. They will be found to endorse the minimum figure of 80 beds from the various standpoints considered.

1. **Undergraduate Teaching.**

At Guy's the average number of undergraduate students in each clinical year is approximately 100. Clinical appointments are for 3 months each and this means that approximately 25 students are doing a particular appointment at any one time. For their psychiatric appointment these 25 are divided into two firms of 12 or 13 students each. It is our unanimous opinion that each student should have the opportunity of clerking not less than five patients in 3 months, that is 500 patients a year. At present, 20 teaching beds in the York Clinic provide approximately 160 patients per year. To provide 500 would therefore require just over 80 beds. The nearest exact figure is 82.

2. **The needs of the parent hospital**
3. **Service to the community as a whole** } can conveniently be considered together. They represent the essentially clinical as opposed to the primarily teaching requirements of the unit. Sources of referral and their implications in terms of potential admissions are set out below.

(a) **Outpatients.**

Approximately 1,000 new cases seen per year: of these one-fifth require in-patient treatment. This would demand a turnover of 200 patients a year from this source alone.

(b) **Internal Hospital Referrals from other departments (excluding emergencies).**

These total at least 100 a year, usually rather more. Of these about a quarter, say 25 patients, require admission to the Unit.

(c) **Emergencies.**

These include both patients arriving at the Casualty Department and Emergency Referrals from other Hospital Departments whether in-patient or out-patient departments. They also total something over 100; one-third of them requiring urgent admission to a psychiatric unit; that is 33 patients per year.

(d) **Special Referrals.**

This term covers all patients specially referred to either of the consultants in adult psychiatry at Guy's. They include members of the medical or nursing profession or their families with Guy's connections; and also patients referred privately who are in fact unable to

pay private fees or afford private admission. The minimum annual figure for these special referrals is between 600 and 700 patients. One third of them require admission, demanding a further annual turnover of 200 or more patients.

(d) **Re-Admissions.**

With the high rate of relief or substantial improvement obtained[11], an average duration of stay of not more than 7 or 8 weeks, and the wide range of patients accepted for investigation or treatment, the re-admission rate is inevitably significant. In practice it can be as much as 20 per cent of the total admissions. Given an approximate total under the four previous headings of 460 patients per annum, re-admissions can be expected to account for another 90 to 100 cases. This gives an overall total of not less than 550 patients per annum. This is unquestionably a conservative estimate and we have already seen that a turnover of 500 patients requires over 80 beds, as set out in (1) above.

4. **Research and Postgraduate Teaching.**

Clearly the size of the unit here is less important than the quality of the work performed, and the teaching of those selected for post-graduate training and research posts. The staffing of such a unit has to take account of all the four items just considered. An 80 bedded psychiatric unit in an 800 bedded general teaching hospital would require :

At least four consultants not less than half-time.
Three House Officers.
Seven Registrars, of whom three would need to be Senior Registrars.
Nursing staff at a ratio of not less than one nurse to two or three patients, allowing, of course, for total day and night duty commitments and prevailing off-duty arrangements.

The functions of such a unit could then extend to cover all the points set out in the four headings above. Even so, they would risk being strained to their limit, so that the amount of time available for teaching, research, and above all for thinking, might yet remain a precious and perhaps a constantly threatened commodity. There is no branch of medicine and surgery more exacting in terms of time and skilled effort than psychiatry, if properly practised, and if accepted in its necessarily wide implication as an established part of the total practice of medicine and surgery as a whole.

Money for the kind of unit envisaged above is unlikely to be provided out of the existent total budgets made available to teaching hospitals, where every department ceaselessly, inevitably, and indeed legitimately competes for every penny that is made available. Nevertheless, in a memorandum specially prepared by Dr. G. C. Tooth, M.D., of the Ministry of Health[12], for the information of Professor Curran and Sir Aubrey Lewis, the estimated need for a general hospital serving a population of not more than 250,000 people was 200 psychiatric beds. He added the observation that in densely-populated urban areas, space within hospitals must be at a premium,

and that for this reason psychiatric units might have to be restricted to 100 beds. Even if we accept a minimum figure of 80 beds, as supported by the present memorandum, as the maximum practical target, it will clearly still be necessary to allocate special funds for the provision of such units in teaching hospitals.

Finally, it must once again be urged that the allocation of 80 beds for psychiatry does not represent an impractical goal, but rather an essential minimum requirement. The York Clinic itself, although just about half the minimum size necessary, is immeasurably better than nothing at all. Yet it came into existence originally only because one man gave the money to build the Clinic, and another man gave the site on which it stands. At the time there was no indication from the Ministry of Health, nor indeed from any other source, that the importance of this gesture, and of its acceptance by Guy's, was understood or even recognised. But in the future teaching of undergraduates and the development of a balanced and humane system of medical care in this country, the place has already proved itself to be worth its weight in gold many times over.

The implications of these facts, and their future implementation, will inevitably fall at least as much upon you, who read this article as members of the present generation of students at Guy's, as it will upon my generation who have helped to create what you see around you here, but who know that our work is very far from complete. Ultimately it will be you who decide the future of psychiatry and Guy's Hospital, just as you will decide much of the future of medicine and surgery as a whole.

As this series of articles will have made clear, there is still much to be done: but ultimately the quality and achievement of any branch of learning and practice, depends upon the quality of training, temperament and calibre of those who undertake it. I, and my fellow contributors to this series, have tried to give you some account of the present, and its roots in the past. Before very long, you will be taking over the future.

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NOTICES

Matron's Ball

This year the Summer Ball was held at Grosvenor House, Park Lane; a new centre for the occasion, which has suffered in the past from being crowded.

There were over 500 guests, welcomed by Matron and Lord Robens, amongst whom were Lady Robens, Dr. Baker, Mr. and Mrs. Beard, and the Chaplain and Mrs. Beevers.

It was an elegant and lively evening, with an excellent dinner. The dancing was well supported by the Lipton Band who provided vigorous and varied rhythms.

The colourful kaleidoscope of the gowns was heightened by spotlights on the dancers, a sight enjoyed by onlookers who could retire to the balcony above the ballroom.

The only hint of regret was perhaps that we couldn't dance all night!

Guy's Hospital Biennial Dinner

To be held at the Connaught Rooms, Great Queen Street, Kingsway, London, W.C.2., on Friday, 7th October, 1966, at 7.0 p.m. for 7.30 p.m. The Chairman will be Sir Rowan Boland, C.B.E., M.D., F.R.C.P. The Biennial Dinner affords the most popular opportunity for old Guy's men and women—medicals and dentals—to meet together and renew the friendships of their student days.

The Hon. Secretary will be grateful if Guy's men and women who intend to be present will apply for tickets (£2 2s. 0d., made payable to Guy's Hospital Biennial Dinner) as soon as possible to the Hon. Secretary, Biennial Dinner, Guy's Hospital, S.E.1. (Tel: HOP 7600, Ext. 341, 342).

Music Circle

A Chamber Concert was given in the Music Room, East Wing, on July 18th, 1966.

An utterly disarming evening was provided by a group of Hospital musicians. The backbone consisted of a recorder ensemble, spiritedly led by Michael Lindop. The recorder seemed to come in all shapes and sizes and one was amazed at the variety of sound. Composers represented included Gabrielli, Gibbons, Jenkins and Telemann.

The first performance of a trio for oboe, flute and piano, by Ian Harrold (b. 1942), provided a great contrast. This four-movement work, with a delightful tango second movement, held one's interest throughout with its Walton and Stravinsky overtones.

The human voice was persuasively provided by Claira Corfe, quietly accompanied by Michael Coe, in songs by Haydn and Bach.

The concert ended with the Piano Sonata Op. 2, No. 1, by Beethoven, played by Christopher Jenney. It was notable for its passion and accuracy—without doubt a high spot of my Guy's music listening.

It is hoped that concerts of this nature will become a regular part of the Guy's scene.

HEDLEY BERRY

Boat Club

ANNUAL GENERAL MEETING, 27TH MAY, 1966.

The President, Mr. Mansie, was in the chair. The captain, P. Burton, reported on a very successful year with encouraging victories in the United Hospitals' and University of London regattas.

Mr. Mansie was re-elected as President, and the following new Vice-Presidents were elected:—Mr. P. Campion, Mr. Ayling, Dr. D. K. C. Cooper. Mr. F. Law, Dr. H. Freeman and Mr. D. Gurney were unanimously re-elected.

The new captain for 1966-7 is M. C. Mace, and hon. sec., G. Stygall. Social Secretary is J. Skuse, and hon. coach is P. J. Burton.

A.G.M. of the United Hospitals' Rowing Club

14TH JUNE, 1966.

P. J. Burton, of Guy's, was elected Captain, and J. H. Williams was elected Hon. Secretary.

Guy's and UNICEF

The sum of £32 18s. 0d. has just been sent to the U.K. Committee for UNICEF. This brings the total collected since the end of 1963 to £701 5s. 10d. In future, money for UNICEF from the Guy's community will be received by the staff of the Wills Library. Dr. B. L. Coles, of the Physiology Department, will arrange supplies of UNICEF Christmas cards later in the year.

D. J. ANDERSON.

CORRESPONDENCE

South African Promise

SIR, Mr. T. L. Lewis has not really answered (your issue 23rd July) the courageous letter of protest from Dr. Stafford-Clark in which he protests against evil and injustice and imprisonment without trial in South Africa (9th July, 1966).

Here are some unemotional facts for Mr. Lewis.

Problem of multi-racialism:

" . . . It is unlawful for a White person and a non-white person to sit down to a cup of tea together in a tea-room in a town anywhere in South Africa, unless they have obtained a special permit to do so . . . "

Proclamation No. 164, dated 4th July, 1958, issued pursuant to Sec. 1(4). read with Sec. 1(1) (vi) of the Group Areas Act No. 77 of 1957.

Imprisonment without trial:

" . . . The Governor-General (in special circumstances, the Minister of Justice) may, if he is of the opinion that the safety of the public is seriously threatened and that the ordinary law of the land is inadequate, by proclamation, empower any police constable to arrest any person and imprison him without trial . . . "

Public Safety Act No. 3 of 1953, Sections 2, 3, and 4.

"Whiter than white"

"The register of the population of the Republic of South Africa contains the names of citizens whose names must be classified by the Director of Census or his deputy as a White person (which means 'a person who in appearance obviously is, or who is generally accepted as a white person, but does not included a person who, although in appearance obviously a white person, is generally accepted as a coloured person'), an African (which means 'a person who in fact is or is generally accepted as a member of any aboriginal race or tribe of Africa'), or a Coloured person (which means 'a person who is not a white person or an African'), as the case may be."

Population Registration Act No. 30 of 1950, Sec. 5.

"The Bantu is better off", says Mr. Lewis.

In 1965 the British Council of Churches published a report of a study which they had prepared on South Africa (The Future of South Africa, A Study by British Christians). Here is the relevant paragraph on Finance.

"In 1955 (with the Bantu Education) . . . a fixed sum was laid down as the annual contribution from the Consolidated Revenue (of the country), £6,500,000. All expenditure beyond that, however much the demand for African education grew, must be met from African taxation. The only figures available for a comparison of the net annual costs per pupil in other communities refer to the Cape in 1960-61. For white children the figure was £72 5s. 0d.; for Coloured, £29 10s. 0d. In the same year the figure for Africans throughout the country was £6 5s. 0d. . . . ".

If Mr. Lewis has not read "Tomorrow's Sun", by Helen Joseph (Hutchinson, London, 1966) "a smuggled journal from South Africa", I would urge him to do so, and see what happened to a courageous woman, a Christian, with an enlightened, humanitarian outlook.

Yours, etc.,

H. N. LEVITT

London, N.W.1.

SIR,—Tom Lewis and I have been friends for over twenty years; so it was as melancholy for me to read his expressions of surprise at my lettter, as it may well have been for him to record them. But is it really surprising that a doctor should reluctantly conclude that a malignant condition carries a grave prognosis? or that I should feel concerned about what would be equally wrong anywhere, just because it is six thousand miles away? The implications of the rest of his letter might at first sight seem to be that white supremacy is the only answer to a multi-racial society, and that a police state, with neither votes nor justice for the majority of the population, is the necessary condition of such an answer. But he avoids these conclusions by revealing his own distaste for racial prejudice in Britain (a distaste which I unreservedly share), and a hope that enlightenment may soon be on the way in South Africa—a hope which I wish I could share. However, the experiences of such men as Patrick van Rensburg[1], Govan Mbeki[2], both of them like Mr. Lewis himself, South African born, and of women like Helen Joseph[3] and Ruth First[4] give the lie to such facile hopes.

I am sorry that " the Bantu " and his standard of living have been specifically invoked. Bantu is a collective term coined by the proponents of apartheid to describe black Africans; in the tradition of "Kaffir", "native" and the Rhodesian "munt." " Better off economically" neglects the predicament of forced black labour on white owned farms, and men and women "endorsed out" to the Transkei and other reserves, where the per capita income can be less than a pound a week.

I had not intended to re-enter this correspondence, and if the letter to which I am replying had not been from someone whose accustomed clarity of thought and lucidity of expression have long commanded my respect, I doubt if I would have written again. To provoke a personal friend into equivocal support for a policy based on indefensible principles, is an unedifying experience. Even so, nothing in Mr. Lewis's letter contradicts the truth of what I originally said. This is how one Afrikaner has described the situation "; . . . the tragedy of misunderstanding that has unfolded in South Africa, where a frightened people have become committed to a course of action, and are unable to see how the present attempt to safeguard their future is the very factor most likely to destroy it."

Yours, etc.,

D. STAFFORD-CLARK.

Guy's Hospital, S.E.1.

(1) van Rensburg, Patrick: " Guilty Land." Penguin Special S205.
(2) Mbeki, Govan: " The Peasants' Revolt." Penguin African Library, AP9.
(3) Joseph, Helen: " Tomorrow's Sun." Hutchinson, London.
(4) First, Ruth: " Hundred and Seventeen Days." Penguin Special, S244.

van Rensburg and Ruth First are both exiled after indictment by the South African Government. Mbeki is in prison, and Helen Joseph is serving a sentence of five years' house arrest; both in South Africa.

"The Thatchings", Bognor Regis, Sussex

SIR,—Mr. Lewis, the Manager of " The Thatchings ", has had to retire on medical advice following his recent illness, and, as a result, "The Thatchings" will be temporarily closed from the 1st August. While the building is closed, we are taking the opportunity of renewing the central heating, and we are, of course, looking for a couple to replace Mr. and Mrs. Lewis.

I thought that those of the Hospital staff and students who might be thinking of going to " The Thatchings " during the next two months would wish to know of its temporary closure.

Yours, etc.,

P. LE FLEMING,
Assistant Clerk to the Governors

Counting House,
Guy's Hospital, S.E.1.

Sister Arabella

SIR, Extern, weary and saddle-worn at 2 a.m., will always remember meeting Sister Arabella in the Park, to be greeted with the comforting remark of "Ah! another little Bundle of Love!"

Yours, etc.,

L. K. ROBSON

The Keys,
Herstmonceux,
Sussex.
25th July, 1966.

A Matter of Life and Death

SIR,—In the *Gazette* recently the Nursing Section considered the problem of when and where not to institute cardiac resuscitation. Sister Glover states: "It is time the nursing staff demanded some guidance on this from the medical staff? Is it not possible to bring this problem to a head now by a discussion amongst those most concerned?"

I am not surprised to note that so far no one has replied, for there is widespread reluctance among the medical staff to involve themselves in any topic which is as highly emotionally charged as the subject of Death.

The recent London Hospital Symposium on Death illustrates this attitude by stating in the introduction: "Although it is proposed to avoid philosophical discussion." It might just as well have read "Although it is proposed to avoid the true problem of Death."

Not knowing then that it was practised at Guy's, I asked if it was advisable to decide whether or not to resuscitate before the event rather than leaving the nurse to decide in the few minutes after an arrest occurs. The only answer I received was "We cannot act like God." I am afraid such a meaningless statement cannot be called "guidance", and that true guidance is unlikely to come from a profession that has largely chosen to avoid the question of death and dying.

The problem has two main facets: one is purely a local one—it concerns an individual patient, his medical prognosis, his family and social environment, even his own attitude to death. All these must be considered by the nursing, medical staff and relatives together, after which a decision is made on whether or not to resuscitate. God or no God, such a decision shows more moral integrity than to leave it to some individual who happens to be around at the time of arrest.

The other facet of the problem is one of our general attitude to Death. Robert Fulton said: "Death now becomes an infringement upon our right to life, liberty and the pursuit of happiness. We cope with it by choosing to disguise it and pretend it is not the basic condition of all life." Eventually we will stop regarding all deaths as undesirable and may even realise that by letting someone die, we may avoid hindering them from achieving a death that is even appropriate.

Yours, etc.,

M. E. PEMBREY.

East Wing.

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"RAIN"

A REVIEW

The Theatre Club presented David Graham's production of John Colton and Clemence Randolph's "Rain" for their third production this year. "Rain" is a dramatisation of Somerset Maugham's admirable short story "Miss Thompson." This account of the strange efforts of the Rev. Davidson to save the soul of the easy-living Miss Thompson, during the enforced stay of the passengers of the "Orduna" passenger ship on the island of Pago Pago, adapted well to stage presentation, and kept the audience interested until the dramatic final moments of the play.

The scene of the play is in the public living room of Joe Horn's Hotel Store on the island, and Max Pearce and his assistants produced an excellent set. Mr. Pearce is proving a worthy successor to Mr. Jim Brammer—and I can think of no greater compliment than that.

The natives were charmingly played, and Mr. Christopher Doyle in his brief appearances came near to stealing the scene. Jean Marpuga deserves special mention for her interpretation of the storekeeper's native wife—I thought her's the best performance of the play.

Andrew Seal was disappointing as the Rev. Davidson—this fine actor never seemed at home in this part. Jenny Wakelin made a good attempt at the part of his poor frustrated wife. Dick Illing as Dr. McPhail, needed to be a much more definite personality—this was a failing of most of the players; apart from Miss Marpuga, they failed to develop the characters of the people in the play. Penelope Rench played Mrs. McPhail in the style of Mary Pickford, star of the silent screen. The audience loved every moment of it, laughing hugely at every sentence. But I don't think Maugham meant it that way.

The American members of the cast found the accent heavy going. Mr. Graham would perhaps have been wise to have Anglicised their parts, thus giving them a chance to relax more into the characters they were playing. Alison Stevens did well to keep her accent going most of the evening, although it lapsed somewhat in the second act. She made a good attempt at a difficult part, and with more support from the other members of the cast, this would have been a good performance.

Peter Davenport as the lazy whiskey-drinking store proprietor, was extremely good at the beginning of the play, but seemed to lose his enthusiasm as the evening wore on.

We must give special thanks to David Graham, who once again agreed to produce for us when he so much prefers to be acting. Perhaps October will bring us a keen producer—where are those at Guy's anxious to try their hand at this most exhausting, difficult, frustrating and yet very satisfying job?

H.B.P.

NURSING SECTION

Ward Receptionists

In order to keep in step with the times, the hours worked by nurses have been reduced to 42 hours per week. These hours will soon be considered out of date and one can envisage a shorter and shorter working week. Inevitably with a shift system and shorter working week there must be recruitment of more nursing staff to cover the wards and keep up the high standard of nursing that Guy's offers to its patients.

Recruitment of trained nursing staff has been a major headache to all Matrons of hospitals both metropolitan and provincial for a number of years and this is now manifoldly increased. There are a number of suggestions for solution of this problem, and one of these is the employment of lay personnel to work in the wards.

A number of hospitals have employed these non-nursing staff on a trial basis over the last few years. The experiment, according to the Institute of Hospital Administrators' report, published in early 1966, makes a tremendous impact on the work load of the ward sister. The suggestion was made at that time that a re-allocation of ward duties should be made. All work not requiring nursing skill, nursing care or nursing observation should be the responsibility of a receptionist/housekeeper team with the members of the team responsible to the ward sister and the hospital secretary.

There are a number of fancy titles given to these lay personnel—Ward Housekeepers, clerks, assistants, aides and orderlies, hostesses, receptionists, etc. Their rates of pay, hours and duties are as varied as their titles suggest.

At Guy's two ward receptionists have been employed—in Caleb and Diplock and Victoria Wards since late 1965. At the time when this idea was first discussed one senior disapproval was voiced—that too much of the ward sister's territory was going to be encroached upon. This difficulty has now been overcome, and the ward sisters would be the first to say how invaluable this lay help has become.

Great difficulties have been found when thinking of the type of person to recruit, whether the receptionists on the whole should be young or middle aged. The problems are that they should not identify themselves too closely with the patients; there must be no feeling on the receptionist's part that they are the "king pin"; that they are to be direct assistants to the ward sister and not—especially if they have secretarial knowledge—to the medical staff.

The applicant envisaged must be fully mature and the job itself is about the most interesting and varied that anyone with a taste for daily changing routine and personal contact could wish for. Personality, adaptability and sound common sense are the only basic qualifications needed. No experience of hospitals need be necessary.

The introduction of these personnel will call for a certain amount of time to be devoted by the nursing staff in the initial stages. It has been said that there will have to be a close watch kept upon the receptionists while they find their feet. The right type of general and gentle introduction will be necessary and it will be some time before the pure nursing will become separate from the administrative tasks relevant to a receptionist. A receptionist, however, is the answer to any harassed ward sister's prayer. To have someone to answer the telephone and deal with the 101 small and irritating, non-nursing, ward administrative tasks will provide welcome relief.

Decision has yet to be made upon the precise duties which will be undertaken by the receptionists and which will be issued over the next few months. There are initially to be seven receptionists installed—one between every two medical wards. As a new venture this will be constantly under review.

In time, as the receptionists become more and more invaluable, it will be necessary to make sure that there is delegation without the delegator losing track of the work carried out. Inevitably it will be impossible for replacements to be made in times of sickness or holiday, but this difficulty will be overcome. Maybe in years to come there will even be formation of a shift system of ward receptionists but this will not be possible at the moment.

Responsibility for the receptionists comes under the wing of the hospital

secretary, and they will be paid in a clerical wage bracket according to their age. Local responsibility will of course be entirely the task of the ward sister.

The introduction of receptionists in the Medical wards should be completed by the end of this year and this will be a welcome step made by the authorities and will be greatly appreciated by the nursing staff.

Miss Doris Chrimes

On July 16th, 1966, Miss Doris Chrimes retired after thirty-four years' service at Guy's.

The Sister's posts she held sound like battle honours of some regimental colour—Night Sister, Miriam and John, Pembury, Surgical Night Sister, Nuffield A Floor, Mary and Outpatients. Wherever she worked she showed outstanding efficiency, energy, and vitality.

She was one of the great personalities of Guy's whose crisp utterances will long be remembered, repeated and laughed over. Her tremendous sense of humour and her quick wit, her love of a good argument and her delight in a spirited rejoinder, were well-known. Perhaps not quite so obvious was her great kindness. She spared herself nothing in order to help those in real trouble, but with those inclined to self-pity, she could be astringent. But perhaps her most marked characteristic was her loyalty—to her nurses, her patients, her country, her religion, and to Guy's. To her way of thinking there was no other hospital in the same class, and she spent her years here with single-minded enthusiasm, teaching and exemplifying the training methods and traditions of Guy's.

She will be much missed—by the nurses for her sound and thorough training; by the patients for her care and kindness; by her friends and colleagues as a good companion and true friend; and by Guy's as a devoted daughter and excellent nurse.

Our good wishes go with her for happiness in the vast and varied new activities she has planned.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister R. M. Adams Acton, R.S.C.N., S.R.N. (Queen Mary's Hospital for Children, Carshalton, and The Lambeth Hospital) to be Administrative Sister at the Evelina Hospital.

Sister M. J. Harris, S.R.N., S.C.M. (Royal Victoria Hospital, Bournemouth) to John Ward.

Sister E. A. Redpath, S.R.N. (Royal Free Hospital) to Mary Ward.

S/M M. Dobson, S.R.N., S.C.M., to Victoria Ward.

PROMOTION

Sister M. Phillips to Theatre Superintendent.

DEPARTURES

C/N C. Turner, from Cornelius.
S/N D. Bell, from Cornelius.
S/N E. Catto, from Diplock Night Duty.
S/N B. Hindle, from Mary Night Duty.
S/N P. A. Lewin, from Surgical X-ray.
S/N J. M. Hapgood, from York Clinic.
S/N A. Martin, from Theatres.
S/N K. Matthews, from Casualty.
S/N I. Welch, from Diplock Night Duty.
S/N D. White, from Martha Ward.

The Duke of Edinburgh Gold Award

We congratulate **J.S.N. J. M. Horn** on winning the Duke of Edinburgh Gold Award.

THE NEW PLAN OF TRAINING

by

Sister Brysson Whyte

Principal Sister Tutor

The girls who entered the School of Nursing in October, 1965, are making Guy's history. They are the first set to start training under the new (1962) syllabus. The concept of the new syllabus is simple. After a short introductory course of not more than eight weeks, the student enters a rotation of carefully planned practical experience. As far as possible theory should be correlated with practice, and the bulk of theoretical teaching should be complete by the end of the second year. Basic anatomy and physiology are now taught throughout training and the Preliminary State examination has been discontinued.

The Introductory Course.

Sets of 75 nurses enter three times a year. The key to the new Introductory Course is that nurses are now living at Guy's and able to go in and out of the wards easily. The basic plan is that practical work should be very closely supervised for the first four weeks but during the last four the nurse is left on the ward for longer periods to work with the ward team. During the first weeks the seven practical tutors take fifteen nurses into the wards each day to perform specific tasks. When these are completed they return to the classroom. During the first four weeks the nurses and their tutors serve tea, make empty beds, carry out the morning toilet of patients, serve lunch, see a patient admitted and watch dressings (among other things), all in a real ward setting. Further practical practice must continue in the classroom, but its relation to the real situation is easier to understand. In the fourth week the nurse is allocated to her own ward where over three weeks she will work a morning, an evening, and a night shift so that she can see the pattern of the patient's day.

First Year Allocation.

The first allocation is for a period of 30 weeks, divided into three periods of ten weeks. The allocation is fixed so that one third of the group gain surgical experience, one third gain medical experience and the remaining third either gain paediatric experience or work in Nuffield House. After ten weeks they move on and eventually complete their experience in all three areas. It is very important for the tutorial staff to keep in touch with nurses during their first months on the wards, so the extra fifteen days which used to form part of the old introductory course have been divided into study shifts.

The nurse in the surgical ward has one study shift a week for five weeks as does the nurse in the medical ward. These are planned to relate to medical and surgical patients and in fact are usually patient centred. A typical day would include a class on the relevant anatomy and physiology, a visit to the patient followed by discussion about his drugs and treatment and practice in the appropriate nursing procedures. Free discussion about problems encountered in the ward situation is also helpful to the nurses at this stage. Nurses entering the paediatric ward have a brief five-day "course" before they start in the ward.

Second Year Allocation.

After a holiday and a six week school, the nurse enters her second year allocation, which is a series of placings in special departments. Over a period of approximately 38 weeks she will work in Casualty or Out-patients, Theatres, York Clinic and either the gynaecological or the obstetric ward. It is hoped that "rotating" night duty will be possible during this period.

Third Year Allocation.

After a second holiday and school, the nurse returns to the general wards to gain senior experience in Medicine, Surgery and Paediatrics. Careful planning is necessary so that nurses who have worked in specialised surgical wards work in general surgery during their second allocation and vice versa. A third holiday, followed by a three week school, is given early in the third year, and the hospital final examination takes place a few months before the State Final Examination. Immediately following State Registration a week's In Service Training is given to the newly qualified nurses.

Problems.

It would be idle to suggest that all this change could take place without an immense amount of time, effort, and goodwill being spent on all sides. The Ward Sisters have to release junior nurses for study shifts. The Tutors have to reorganise all their teaching programmes. The Allocation Sister has to make sure that vacancies exist in the wards to which it is planned to allocate a nurse. To make the plan function at all it is necessary for all those who entered before June, 1965, to have completed their special experience by September, 1966, and the Theatre Sisters are at present receiving batches of six nurses for specially arranged two-week courses to make this possible.

Changing from four intakes a year to three has meant that the old schedule of four thirteen week night duty periods a year has to be altered and Night Sister has to bear the brunt of these difficulties. Doctors are having to alter lecture schedules and to put up with an increasingly mobile staff of nurses until the special allocation rotation is running smoothly. However, Doctors, Sisters, Nurses and their Tutors are not putting up with all this inconvenience for nothing; the aim of Guy's, as of any hospital, is to give a better service to the patients, and if we can give the Guy's patient a more rationally trained and better prepared nurse we will have done him a great service.

SPORT

Pride of place this week must go to the Tennis Club, who retained the United Hospitals' Cup on July 25th by defeating the London Hospital by six rubbers to two. This is the thirty-second time Guy's have won the Tennis Cup, and the fourteenth success since the war—obviously a very fine achievement.

The Nurses' cricket match on July 23rd was a great success. Full credit to the Nurses for winning by 2 wickets. Admittedly the cricket club batted with shaved down bats, and some of the umpiring decisions were a little dubious, to say the least, but all the same, the ladies, many of whom had not touched a bat for years, played well to register their first win. It is rumoured that one or two of their team were on this year's cricket tour!

Another cricket match arranged recently was between a team representing the College and one representing Sophie's. Again some remarkable umpiring decisions at very opportune moments, for the fielding side were the outstanding feature of this game. From all reports, the standard of bowling was rather low, although nobody was called for throwing. As to who won is a matter of some conjecture, depending on which side you support, but an honourable draw is probably nearest the mark.

The Cricket Club have been on their annual tour to Sussex during the last week, a full report of which will appear in the next issue. They had at least one good win against Littlehampton, winning by 86 runs.

The next winter season is only six weeks away, and the Rugby Club have already started training—or at least some of them have. Unfortunately they have lost one or two more of the stronger fixtures, but there is a good chance of playing Oxford University some time in October or November.

DIARY

CRICKET.

August:

Sun., 7th—Madhatters. 11.30 a.m. Home.

Sun., 14th—London New Zealand. 2.30 p.m. Home.

TENNIS.

August:

Sat., 6th—Park Langley. Away.

LAWN TENNIS

Once again Guy's have won the United Hospital Championship by defeating the London Hospital by six rubbers to two on July 25th at Honor Oak Park. The score does not really underline Guy's superiority because, having won the match 5—0, the last three rubbers were played with an air of gay abandon and resulted in the London winning two rubbers as a consolation. A full report will appear in the next issue.

Guy's had reached the final by defeating the Middlesex Hospital by nine rubbers to nil. So great was Guy's superiority that Middlesex, who were probably one of the weakest sides ever to reach this stage of the Hospital Cup, managed to win only 18 games in the nine rubbers. This was hardly the kind of practice needed before the final but fortunately the club matches provided stronger opposition resulting in Guy's win in the final.

The new fixture against Sundridge Park "A" was narrowly lost with Hughes and Sole only losing 7—9 in the final set of the deciding match. Such a result against a team containing a Kent County pair was a great encouragement. Another good result was obtained against Shooters Hill, who had beaten Guy's 9—0 in the first match of the season. In the return match Guy's were leading 4—3 when rain stopped play. Hopkins and Newman won their three matches despite Hopkins breaking his racket clean in two with powerful smashing! Hayhow, having finished with exams, was playing for the first time and he and White provided the other victory by beating the Shooters Hill 2nd pair having previously lost to their 3rd.

Guy's had to field a weakened first team against Midland Bank and consequently lost 3—6, despite Sharp and Machell winning all three of their matches.

The 2nd VI have continued their successful run, beating Charing Cross Hospital and University College Hospital 1st teams comfortably.

J. NEWMAN

GOLF

STAFF v. STUDENTS

At Hunter Combe. July 10th

Twenty hardened golfers presented themselves on the 1st tee at 9 a.m. for this annual fixture, the staff side bristling with confidence and generous handicaps.

Their confidence was not misplaced, and they finished winners for the third year in succession. Various reasons have been advanced for the students' depressing inability to win at Hunter Combe. The fiendish choice of venue by the staff is probably the most convincing.

Hunter Combe fairways have to be trod in single file, and are surrounded by areas of Oxfordshire's premier jungle. Thus the staff, most of whom can see on Sunday mornings and to whom the loss of a new Dunlop 65 is an

obvious candidate for expenses occurred on domicilary visits, have a gross advantage from the start.

Results:—

a.m.

1. Mr. Lewys Lloyd and Professor Cohen halved with A. B. Bevan-Jones and R. Smith.
2. Dr. R. Lascelles and Mr. Lewis lost to V. G. Williams and M. J. Brummitt, 3 and 2.
3. Dr. MacLean and Mr. Brain beat P. D. M. Ellis and D. Evans, 6 and 4.
4. Dr. Mackenzie and Dr. Houston beat E. S. Baird and P. Mewton, 3 and 2.
5. Dr. Dow and Dr. Seward lost to A. Curry and A. Phillips, 7 and 6.

p.m.

1. Mr. Brain and Mr. Lewys Lloyd lost to A. B. Bevan-Jones and M. J. Brummitt, 2 and 1.
2. Dr. Houston and Professor Cohen halved with P. D. M. Ellis and P. Mewton.
3. Dr. Lascelles and Dr. Dow beat A. Curry and V. G. Williams, 3 and 2.
4. Dr. MacLean and Dr. Seward beat E. S. Baird and R. Smith, 6 and 4.
5. Dr. Mackenzie and Mr. Lewis beat A. Phillips and D. Evans, 2 and 1.

Match result: Staff 6, Students 4.

Bevan-Jones persuaded Smith, our secret weapon, to leave his driver in his bag, in the interests of playing a second shot with the same ball, with gratifying results.

Williams hit innumerable superb iron shots, and only rarely looked surprised afterwards.

Dr. Lascelles, whose driving in the morning had a bend like a Brazilian free kick, reversed his shoelaces at lunchtime, and thereby rejuvenated his entire game. Ellis was seen to hole a huge putt to win his afternoon match with scarcely a tremor.

However, the feat of the day was Dr. Mackenzie's, who, seeing the opposition's ball one foot away on a short hole, suggested a hole in one would probably be appropriate, and proceeded to do just that. With his face the picture of abject misery he confessed to the deed in the bar, and drinking commenced rapidly at his expense, Mr. Lewis proving himself a true friend by ordering a mere half-shandy.

The evening's money match between Dr. MacLean and Bevan-Jones, and Mr. Brain and Ellis, always played in an atmosphere more suited to a world championship fight, was further enlivened by preceding political manoeuvres on the part of one consultant suggestive of the early days of the Mafia, and by teeing-off time the stakes had reached a height that would have interested the Prices and Incomes Board.

Dr. MacLean and Bevan-Jones started with some uncharacteristic visits to darkest Oxfordshire, and were soon four down. Ellis meanwhile, activated by purest mercenary lust, refused to disturb his driver, and played beautiful golf using irons all the way. The inevitable recovery came, but with the score back to one hole, Mr. Brain effectively settled matters with a very long putt, and he and Ellis won 2 and 1.

Shortly afterwards, both Consultants were driven to secret training camps somewhere in the South of England to begin preparation for next year's match.

M. J. BRUMMITT

BOAT CLUB

THE HOSPITAL BUMPING RACES, 1966

1st VIII. Finishing postion, 4th.

Crew:

Bow R. Mandeville
2 M. Preece
3 G. Stygall
4 P. Burton
5 M. Mace
6 R. Forrest
7 P. Pook
Stroke P. Telling
Cox T. Kirk

The "Bumps" were held during May, and all the Guy's crews did well, especially considering the lack of training time available. The overall length of the race had been extended to its former position, now finishing at Kew Railway Bridge instead of the road bridge. This meant approximately a further two minutes' rowing, and so was reserved for the 1st division, there being some doubt on the stamina of the 2nd division.

On the first day of racing Guy's 1st VIII started 5th (finishing position last year), with Westminster ahead. After a rather hectic start Guy's rapidly closed the gap to within six feet, but at this point of history, never to be forgotten, the rating unaccountably faltered—almost stopped. The crew had gone berserk and a row-over was the inevitable result.

The next day arrived with some tension in the crew, and when the start came Guy's were well in position and very determined. Starts in practice were better than ever, and the tactics for the race had been drilled into the crew—simply to go "flat out" whatever the rating. In fact, the start was superb at 40 strokes/min. and settled out to 36, putting Guy's within half-a-length. Both crews were going very hard, but Guy's had more confidence, and succeeded in bumping just below Brentford Dock.

On the third day of the Bumps, Guy's started 4th with St. Thomas's ahead, and very determined to catch them in the same way. The start went well enough to put Guy's in a good position and gradually we closed the gap to within half-a-length at Brentford Dock. This continued to the bend, the rating going higher and higher into the 40's. Coming into "Horse-ferry reach" the pitch began to have some effect, and Paul Telling at stroke did well to steady the crew into a new stride. By the bridge the gap between the crews stood at one length and Guy's put in a spurt for 28 strokes. Again the gap closed and it looked at though we had got them, but unfortunately this was not to be so and both crews finished feeling very tired.

The Bumps Supper, now to be held annually after missing a few years, served to stifle any disappointment and to revive the oarsmen who had entered for the following day's regatta.

P. J. BURTON

2nd VIII

Starting in the first division, the 2nd VIII was the only crew not to gain ground in the U.H. Bumps.

On the first night, after a slow start, the crew was very unfortunate to miss catching the Bart's crew ahead, and for a long way our bow was over-lappng their stern. We confidently expected to catch them on the second night with a better start, but this was not to be. Furthermore, a St. Thomas's crew behind looked very menacing.

On the last night, Bart's, ahead, made a bump against a Royal Vet's crew, so preventing our catching up with them. The row became a battle to prevent Thomas's catching us. This they did inexorably and well about five minutes after starting. The cox still has some sore ribs.

J. WILLIAMS

Crew:
Cox P. Jago
Stroke J. K. Skuse
7 N. Pinckney
6 A. Hodgkisson
5 J. Swain
4 P. Hunt
3 J. Williams
2 P. Moulder
Bow P. Sharpe

3rd VIII

Having lost at least two minutes, due to unfortunate circumstances, at the start of the first day of the bumps, the crew rallied very well and managed to bump the crew in front within half-a-mile of the start.

On the second day the crew started well and settled down comfortably to catch the crew in front easily in slightly less distance than the previous day.

On the third day, having made a very good start, the crew caught the crew in front before it had got into the stream. This took under twenty strokes.

The crew started 21st on the first day; it now lies 18th. A Guy's third VIII did not row in the bumps last year but this year the crew has established itself on the programme.

The Guy's third VIII was the only crew in the event which managed to bump on all three days, which is a commendable achievement continuing the successes of Guy's Hospital Boat Club this season.

N. DAVIS

Crew:
Cox Mansell Thomas
Stroke K. Sommi
7 N. G. Davis (capt.)
6 R. Tudor-Williams
5 J. Rosenburg
4 A. Bell
3 M. Bishop
2 N. Longhurst
Bow J. Bates

The Allom Cup Regatta, 1966

This was held immediately after the Bumps, making a marathon of four days' rowing. Two scratch clinker fours, a coxless four, and a sculler were entered. The coxless four rowed in the morning against a crew from St. Thomas's, and although leading from the start did not manage to hold them off long enough, and lost a good race by a small margin.

The "A" clinker four rowed in the afternoon against L.S.E. and Imperial College. Although rowing an extremely good race, leading off the start at a markedly lower rating than anything on the river, Guy's lost the lead at Quintin B.C., losing to Imperial College by just over a length at "The Ship".

The "B" crew rowed well to win their first race against U.C.H. and so reached the final. In this they met Imperial College and Queen Mary College, and in a very close race led off the start. The launch was full of Guy's supporters, and a great deal of satisfaction was gained by seeing the sheer guts and determination Guy's put into their race. Unfortunately, Guy's came last, losing by a short canvas to Imperial College; Q.M.C. winning the event.

In the sculling, P. Gooder was entered in the Junior sculls where he performed well, but was beaten in a semi-final. However, the sculling that he achieves promises well for the future.

P. J. BURTON

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Neurology,** for a period of one year from 1st October, 1966. Forms of application are obtainable from the Superintendent, and should be returned not later than **20th August, 1966.**

DERBYSHIRE EDUCATION COMMITTEE
MATLOCK COLLEGE OF EDUCATION

Applications are invited from State Registered or State Enrolled Nurses for the post of **Nurse-Matron**. National conditions of service; salary in accordance with Miscellaneous Grade VI, at present £860 to £960 less a charge of £164 for board and lodging. This is augmented by an allowance of £120 per annum for certain supervisory duties.

Forms of application may be obtained from the Principal, Matlock College of Education.

AWARDS

THE MALLESON PRIZE FOR STUDENT RESEARCH—JULY, 1966
Awarded to D. A. Keith

NEWLAND-PEDLEY MEDAL AND PRIZE, 1966

The First Prize has not been awarded.
The following awards have been made:
Hodivala, R. N.—certificate, plus £10.
Orton-Jones, S.—certificate, plus £10.

DAVID FRANK STURDEE—THIRD YEAR PRIZE

The following awards have been made:
Greenwood, Miss L. F.
Kennedy, D. B.
First and Second
Prize divided equally.
Beale, D. A.—Certificate.

PASS LIST

The Chartered Society of Physiotherapy
Final Examination Results
Miss S. A. More O'Ferrall
Miss M. B. Shirley—credit

BIRTH

CUNLIFFE-STEEL:—On July 12th, 1966, at Lady Kennedy Maternity Home, Umtali, Rhodesia, to Tessa (née Metyard) and Philip Cunliffe-Steel, a daughter, Suea Mandy Mai, a sister for Brooke.

CHANGE OF ADDRESS

FANNING.—Dr. P. P. Fanning, to Altwood Warren, Altwood Road, Maidenhead, Berkshire.

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2036

PASSIM

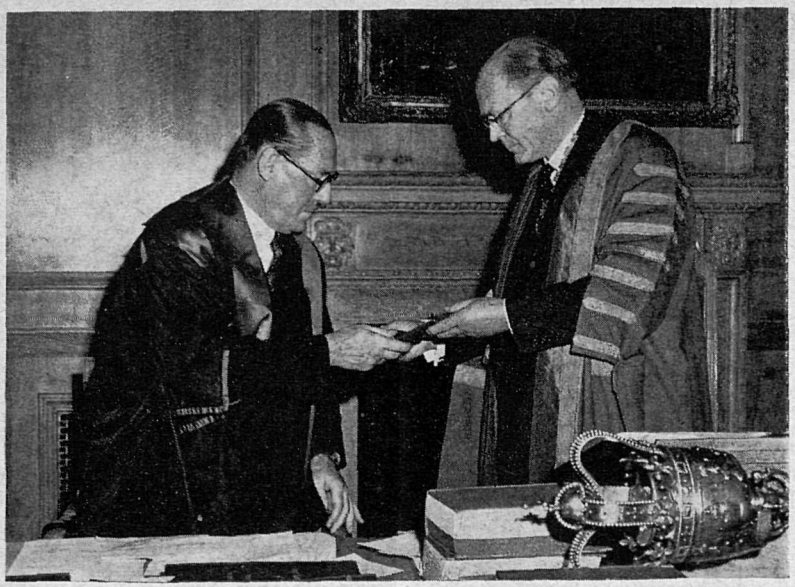
Squandered Visitors

An expanding medical world is one of the most valuable concommitants of the shrinking world of communications. As the birds and flies fly in to enjoy the disastrously short spell of warmth they bring in their wake the tourists—inevitable, but with a significant increase in the medically orientated. As might be expected, most of these visitors cross the Atlantic, bringing with them their dollars, computerised education and an absorbing interest in the British Way of medicine.

All tourists leave measurably far more than they remove. Into the educational freedom wherein Guy's students wallow, the relatively large American contingent presently on the firms has been easily assimilated, yet have left an undeniable mark. This on the facetious plane has varied from relieving the student strain on the currently depleted medical firms through the enlivening quaint pronunciations of medical terms to the introduction of continuous towel units as a hastened outcome of transatlantic amazement regarding the unhygienic single towels in the washrooms. More seriously they have provided an example of industriousness that has often surprised the casual local student, while at the same time they have shown an ease of manner in dealing with teaching staff that has often surprised even more.

Their comments are noteworthy. Hospitality they compliment, even if it is confined to the hospital surroundings. There is some chagrin that their attitudes to medicine and education are little explored, finding that they are regarded as Americans rather than American medical students. They find themselves unable to explain the minimal use of what they consider excellent educational opportunities, believing as they rightly do in the students' obligation to learn as much as possible. To the first two, perhaps there has been to much eagerness to make these guests feel like "one of us" that we are losing their all-important different attitudes and approaches. To the last their compliments are to the hospital and hardly to the student.

There is much to be learned yet at Guy's on how to offer and how best to receive the advantages of exchange. Whatever the hospital motto may be, this transatlantic addition to the educational environment should not be as squandered as so many other aspects undoubtedly are.



Election of new President at the Royal College of Surgeons, July 14th, 1966. Lord Brock receives past President's Badge from the new President, Prof. Hedley Atkins.

P.R.C.S.

Further to our note on Professor Atkins' recent election to the Presidency of the Royal College of Surgeons, we have been furnished with further information regarding the precedent of successive Presidents coming from the same hospital.

Until 1822 there were no Presidents, only "Master's". Under their regime there occurred a curious succession of successions.

Sir Charles Blicke (Barts), Master, 1803 and 1810

Sir David Dundas (Barts), Master, 1804 and 1811

the Mastership being held for one year on each occasion as was the rule.

After the institution of Presidents in 1822, another curious situation arose:—

George Guthrie (Westminster), President, 1833 and 1841;

Anthony White (Westminster), President 1834 and 1842;

again on each of these four occasions the presidency being held for one year only.

Nursing Shortage

It would be inappropriate to publish in this issue, as we intended, any explanation from Matron's office of the causes behind the difficulties confronting the Nursing Staff, because since our remarks in Passim, the matter has been placed in the hands of a Board of Governors' inquiry, headed by Dr. James Fairley. In a future issue, however, we hope to publish a report on this inquiry.

Frozen For Export ?

The pay freeze has consumed much printers' ink within the last few weeks and as far as some doctors are concerned it may well be the last straw. It is obvious, however, that the Government must remain firm; the country has been grossly overpaying certain sectors of its community, albeit partly at the expense of other sectors, but mainly at the expense of the National debt, and this is a state of affairs that obviously cannot go on for ever.

Yet the fact remains that the average weekly remuneration of male manual workers will be frozen at £20 5s. a week for an average working week of 46.4 hours, while that of Junior doctors, to take but one instance, will stay at under half as much for working over twice as many hours. What more can be said?

General Practice

Few would dispute that the bias of present-day medical esteem has become directed mainly towards Hospital medicine, while General Practice has come to be regarded as the poor relation, the branch of service that attracts only those with limited intellectual and professional ambitions. Much has been said about the stupidity and injustice of this situation, which cannot be helped by the fact that all the medical teaching is done by hospital doctors.

Guy's is, however, well on the way towards instituting its Woolwich scheme which will be aimed at altering the bias that exists here. The *Gazette* is starting, in this issue, a series on Modern General Practice, which will attempt to present General Practice in a truer light as a challenging and personally rewarding field that has a great deal of potential for the very best brains in terms of both research and clinical practice.

GUY'S DIARY

Departmental Round: will be conducted by Mr. Colin Howe, F.R.C.S., of King's College Hospital, on Saturday, 10th September, at 10 a.m. in the Clinical Theatre.

Neurosurgical Round: will be conducted by Mr. Peter Schurr, on Thursday, 5th September, at 5 p.m. in the Clinical Theatre.

Obiter Dicta

Young patient to Off-duty Paediatric houseman: "You're not a doctor today, you're just a lady."

A G.P. BY ANY OTHER NAME—!

Some Impressions of a first-time visit to the U.S.A.

By John Fry, M.D., F.R.C.S.
(Beckenham, Kent)

A visit to U.S.A. soon reveals that both they and we, in Britain, are facing extraordinarily similar problems of medical care. Some of these are—the aims and techniques of modern medical education; Subsidisation and involvement of the State (Federal) in planning and financing of medical care; measurement and control of quality of care; provision of medical and social services for the medically indigent vulnerable groups; and the roles, place and functions of the "G.P."

It may surprise readers that "general practice" or more accurately the equivalent of "doctor-of-first-contact" medicine is one of the major problems of medical care in U.S.A. In fact, its theme runs through many of the other problems including education, quality and the provision of care within the community for not only the so-called medically indigents but for the whole society.

As a practising British family doctor on a fact-finding first-time American tour, I was surprised at the eagerness with which I was listened to by our American colleagues. They were concerned to learn from our experiences so that planning for their future medical services might be better orientated.

Thanks to a Milbank Memorial Fund Fellowship I was able to spend two months visiting many centres to see how medical care was being organized and practised.

Current Scene

Why, the reader may ask, is "general practice" such a problem in U.S.A., and why is it exciting so much interest at present?

The reasons are that at present medical care is at a cross-roads. Major changes are taking place in the move towards President Johnson's "Great Society". Policies of health, education and welfare are being re-defined, re-phrased and re-phased. The Medicare scheme is now law and is offering a young, enthusiastic and virile team of top planners opportunities to review the whole concept of medical care and to plan for medicare and after.

High priority is being given to examine the need and place for domiciliary and ambulatory care within the community. Serious questions are being asked about the role of the hospital in modern medical care and whether it is being over-used.

Current Problems

A closer look at medical care in U.S.A. suggests that the **hospitals** are being over-used. M. A. Morehead and his colleagues (1964) in a

recent survey in New York, found that 15 per cent of admissions to hospitals were not necessary. Over-utilisation is encouraged also by the fact that most of pre-paid medical insurance relates only to hospital care and claims can be met only if the patient is admitted. The trend towards specialisation has led to the custom of self-referral of patients to specialists at hospital.

Costs for medical care are rising continually and some of this is due undoubtedly to over-hospitalisation and over-specialisation.

The **quality** of care in hospitals is far from good. In the study referred to by *Morehead et al. (1964), the expert surveyors found that only 57 per cent of the admissions assessed received "optimal care". The rates for the various specialities showed that optimal care was considered to have been given in 80 per cent of obstetric and gynaecological, in 57 per cent of general surgical, in 43 per cent of paediatric and in 31 per cent of general medical admissions. When care was related to the physicians' qualifications it was found that optimal care was provided by 65 per cent of those with their Speciality Boards and by 33 per cent of those with no such qualifications and with no staff appointments in a Voluntary or Municipal Hospital.

One of the recurrent complaints made by members of the public was their inability to find a **personal family physician** who would provide total care for their family on a continuing basis and who would be prepared to visit them at home when requested.

Michael Harrington, in his Penguin book, "The Other America" (1965), reports that a quarter of Americans are poor. These deprived groups, euphemistically referred to as "*medical indigents*", present major problems in terms of medical and social care. Most of these and their families have no regular medical attendant and when they require care they have no alternatives but to use the hospital as their doctor-of-first-contact—an identical situation to that which existed in Britain before the N.H.S.

Facing the planners of medicare and after are the problems of how to provide optimal care for all of the people all of the time and how to make the best use overall of the available doctors and nurses who tend to be relatively over-plentiful in the more desirable urban residential areas and very short in rural and slum districts.

"Doctor-of-First-Contact"

As a British family doctor I soon found out not to use the term "G.P." or "general practitioner" when describing myself. In U.S.A., "G.P." is a relatively dirty word synonymous with a "do-it-all-yourself" doctor who undertakes everything that comes his way. He "has a go" at major surgery, gynaecology, obstetrics as well as the more traditional fields of general medicine and paediatrics. Most of his colleagues look on him as an anachronistic backwoodsman not to be approved of or supported.

* "A Study of the Quality of Hospital Care, secured by a Sample of Teamster Family Members in New York City" (Columbia University School of Public Health and Administrative Medicine, 1964).

I also discovered quite soon that contrary to what I had been told, "general practice" was not extinct but was being practised in all places by a wide variety of doctors. However, it was a different form of general practice from that which exists in Britain.

To understand the situation and to make comparisons I had to disabuse myself of the term "general practice" and to start thinking in terms of the "*doctor-of-first-contact*". Assuming quite fairly, that the patterns of morbidity are similar in U.S.A. and Britain, who is it that sees the patients with upper respiratory infections, with rheumatism, with acute gastro-intestinal upsets, with rashes and other common skin eruptions, with measles, mumps and chicken pox, with personal problems and minor emotional upsets? Who is it, I wondered, in U.S.A. who deals with all these conditions that my patients bring to me in my own practice? Who is the medical man, in fact, who sees the patients and their family when sick, in the first instance? Who is it who carries out the functions of the front-line-doctor who is faced with a relatively unselected spectrum of disease and who sees the common diseases that commonly occur and the rare diseases that rarely happen? Who is it who has to make the initial clinical diagnosis and personal and social assessment? Who is it who has to co-ordinate the available medical and social services? Who is it who is able and willing to undertake the long-term and continuing care that is required so often?

In my travels I found a whole series of doctors who were carrying out many or all of these roles.

In Chapel Hill, Ann Arbor, San Diego, Palo Alto and Saskatchewan, I met and watched *family physicians* who were caring for individuals and families, irrespective of age, sex or disease, just as I am doing in my own practice. They did no major surgery but performed normal obstetrics.

In Sioux City, I visited a *G.P.—Surgeon* who was more interested in surgery than general practice but who perforce had to do both and who in addition to gastrectomies, orthopaedics and gynaecology practised child welfare and cared for emotional problems and dealt with rashes, coughs and rheumatism.

In New York, Detroit, San Francisco and Rochester, Minnesota, I found that the usual doctors-of-first-contact were *paediatricians and internists*. The paediatricians provided primary care for children up to the age of 15 and the internists provided primary medical and usually general gynaecological care for adults.

In many places I also came across *specialists* such as dermatologists, cardiologists, neurologists and surgeons who acted as doctors-of-first-contact and who were prepared to care for conditions outside their own defined specialities.

In all big cities the doctor-of-first-contact for the medically indigent or sick poor was the young resident in the *hospital emergency room* (casualty department). Just as in Britain before the time when all persons were able to have their own personal family doctor the American hospitals in large cities are forced to provide primary medical care. Unfortunately, most of it is on a temporary basis

with no possibilities of continuity of care by the same doctor and with no set-up that can extend the service into the patient's home.

It is evident, therefore, that the equivalent of traditional British-type general practice is, and has to be, practised in U.S.A. It is not referred to as "general practice" and it is carried out by a whole range of doctors with different affiliations, but it is certainly "general practice" as I know it.

A Difference

A big difference between the forms of first-contact-medical care in Britain and U.S.A. is that the Amercian doctor-of-first-contact usually admits and follows his patients to hospital. He provides a much more thorough form of continuing care for the hospital-type illness.

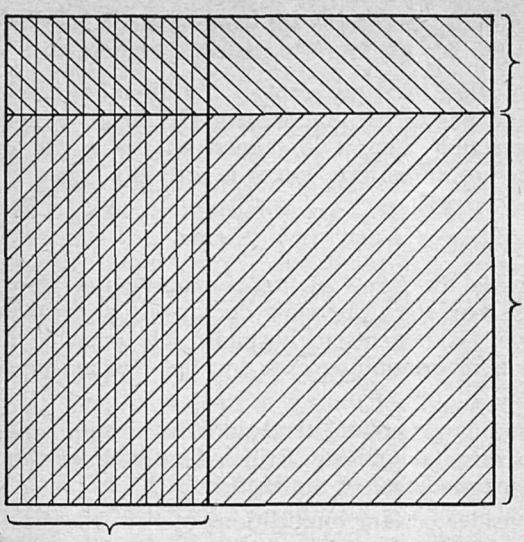
The lack of this continuing care that extends into the hospital, and the absence of access to hospital beds to British family doctors is considered by some as a major defect of the British N.H.S.

It is important to consider certain implications of the American system of hospital care by the doctors-of-first-contact.

Studies have shown that during an average year some 10 per cent of the population in Britain are admitted to hospital each year and 15 per cent are investigated in the out-patient departments (Report of Ministry of Health for 1964). Out of the 2,500 persons that are cared for by a British family doctor some 250 persons will be admitted to hospital in a year for a variety of reasons. In Britain, these are cared for by hospital specialists. In U.S.A., for a variety of reasons, one of which is the fact that the doctor has access to hospital beds, the average number of persons cared for by the equivalent of a British family physician is around 1,500 persons. Of these, between 150 and 250 will be admitted to hospital each year (the American rates for hospitalisation are higher). Since on average the American patient stays in hospital 7—10 days, the American doctor-of-first-contact will have some 3—5 persons to care for in hospital at any one time.

Because the American doctor will have a smaller population to care for, his morbidity experience will be correspondingly less than that of his British equivalent. For example, it is probable that the American internist will encounter about 15—20 adults with acute bronchitis each year, 3—4 cases of acute appendicitis, 5 new cases of coronary heart disease and 5 new strokes. The significance of these figures is that it raises the question of how much clinical material does a doctor require to remain experienced? This really applies only to the solo practitioner. In groups certain conditions will be referred to certain individuals with special interests and so their experience will increase.

The figure shows diagrammatically the difference between the American and British doctors-of-first-contact. Whereas the British doctor has no responsibility for hospital diseases he will have a greater number of non-hospital diseases to manage.



Work of British and American Doctors-of-first-contact.

ORGANIZATION

Features of the American character are voluntary actions, private enterprise and freedom for local initiatives. These features extend into the system of medical care which is based on a pattern of fee-for-service and pre-paid insurance for hospital care. Insurance for total health care is still the exception. No one goes without any medical care, but, as has been pointed out, the medical indigents have no system of continuity of personal and family care.

The doctors-of-first-contact are organized in a variety of ways.

Solo practice is still the most usual form of practice. The work is conducted from purpose-built offices which are generally very modern, well equipped and well staffed.

Group practices are growing in number and in size. They range in numbers of doctors from 2 to well over 100. Many of the doctors are specialists but many also act as doctors-of-first-contact.

Many groups are privately organized but there are growing schemes such as Health Insurance Plan (H.I.P.) in New York, Community Health Association (C.H.A.) in Detroit and the Permanente (Kaiser) Scheme of California, which offers full pre-paid insurance for millions of persons—the premises are owned and the group organized by a central body. The doctors in some instances are employed on a salaried basis and in others are in partnership, sharing profits.

The major differences from British group practices are the excellent premises, organization and equipment; that many of the doctors are specialists; that the doctors have access to hospital beds; and that the sizes of the groups are well beyond anything that exist in Britain—I visited groups of 33 and 50 doctors.

These groups are essentially acting as do our out-patient departments but are combined with general practice as we in Britain know it.

Clinics are even larger group practices and consist of even more specialists and generalists working together as diagnostic and therapeutic units with frequent opportunities for cross referral and with access to local hospital beds.

Examples of two such excellent clinics are the Mayo Clinic with over 1,000 doctors and the Palo Alto Clinic with 110 doctors. In each Clinic doctor-of-first-contact medical care is going on actively.

Hospitals such as Beth Israel of New York, Cornell University Medical Centre and the Yale University Hospital are accepting the fact that primary care has to be given to the medical indigents and this is specially organized to provide a high level of care. The plans at the Governeur Clinic at Beth Israel for providing total care for 150,000 persons in New York's lower East Side are particularly exciting.

COMMENTARY

Whatever his title there is an obvious need for a G.P.-type doctor-of-first-contact in the American as in any other system of medical care. It is, in fact, in this field of care outside the hospitals and in the community itself that some of the major problems of planning for the future exist.

The same three questions that are being applied to general practice in Britain under N.H.S. today can be as urgently applied to the American situation, namely:—

1. What should be the place and functions of the doctor-of-first-contact?
2. What tools and training does he require to do good work?
3. How and who should provide these tools?

Any system in this field of primary medical care should be capable of being extended to the whole population, including the so-called medically indigent and become a part of the greater and wider scheme of social welfare.

It scarcely matters whether the primary care is provided by generalist family physicians or by the more specialist paediatricians or internists. The chief consideration should be to provide high quality personal care in a continuing fashion. There seems to be a current swing back towards the return of the family physician, largely because of the public's demands.

The training for this branch of medicine is just as lacking in U.S.A. as in Britain. The residencies in general practice are largely unsupported and there is no accepted and proven pattern. There are moves towards instituting a Specialty Board in Family Medicine just as there have been moves towards an examination for Membership of the College of General Practitioners, but just as over here there are the problems that unless there are some material benefits associated with the possession of such a diploma there will be few candidates.

The place of the doctor-of-first-contact in the hospital is still unsettled in Britain. In U.S.A. it is the custom for him to continue to carry on responsibility for care once the patient has been admitted. There are problems, however, for studies of quality of care show that optimal care is lower in G.P.-type (proprietary) hospitals and that care provided by non-specialist doctors (G.P.-equivalents) is of a lower standard than that provided by specialists with specialty diplomas.

A marked defect in the American medical scene is the lack of co-operation and association between the various groups providing care outside the hospitals. It is exceptional to see any real teamwork between home nurses (district nurses and health visitors) and doctors, and little evidence of any real attempts to delegate and share work between doctors and nurses in the field of primary medical care. A look at the situation in obstetrics shows that it is customary for all deliveries, normal as well as abnormal, to be handled, quite literally, by a doctor. Midwives are exceptional and not encouraged. It must be stated frankly that this and other examples of over-doctoring are probably related to the system of fees-for-each-item-of-service and closer co-operation between doctors and paramedical auxiliaries will not be achieved until this system is modified.

I wish to thank Dr. Alexander Robertson and the Milbank Memorial Fund for arranging and supporting my tour and to thank all my friends in U.S.A. for receiving me and for exciting so many stimulating discussions that have led to these critical but perhaps constructive ideas.

CORRESPONDENCE

So much more promise

SIR,—I have just read the letter in the *Gazette* of July 9th, from Dr. Stafford-Clark, concerning South Africa. As an old friend and contemporary of his, I find it difficult to understand why he felt constrained to write this rather irresponsible and misinformed letter.

One thing Guy's has always taught its students is to take a complete history and to examine the patient with meticulous care before making a diagnosis or suggesting treatment, and I feel sure Dr. Stafford-Clark, in his department, has always taught these very same basic principles which are so important to medicine.

Why then must my old friend suddenly abandon all these principles so carefully instilled at our alma mater and launch into an almost hysterical criticism of a country which to my knowledge he has not visited recently and certainly never lived in? Like all Guy's men, I have been delighted to meet and entertain members of the Guy's staff and particularly our old teachers who visit us out in South Africa from time to time, and I think they are in a better position to criticise or comment on South Africa than Dr. Stafford-Clark, whose history-taking and clinical examination appears to be hardly up to Guy's standards.

As an Englishman who has lived out here for nearly twenty years, of which seventeen I spent as head of the Department of Dermatology at the King Edward VIII Hospital in Durban, I have learned something of the many problems of this country. This hospital, incidentally, has about 1,800 beds and over 600,000 O.P. attendances by non-whites every year, all this at the expense of the white taxpayer.

In my work there, I began to understand something of the problems of a multi-racial society, and with the establishment of a Medical School for non-European students, one got an even closer view of these problems. I now regard those years as some of the most stimulating and fascinating of my life. It is a tragedy that so many people in England appear only to read sensational newspaper reports or see the grossly biased television picture of South Africa. They seldom, if ever, hear of the enormous amount of work done by private individuals and the City Councils, Provincial authorities and the Central Government, for the African, in providing him with good accommodation, a free health service, and other amenities to improve his standard of living.

I have never voted for the present Government here, yet as a fair-minded person I must protest against Dr. Stafford-Clark's irresponsible indictment which appears to spring from emotion rather than a carefully balanced and considered judgment. He must surely realize that the majority of African States have virtually declared war, even if it be a cold war, on any African country harbouring whites who are trying to keep that country up to the standards it has always had. In war desperate measures may be required and only those who know something about current events out here are in a position to criticise. South Africa has an immense problem, which at least she is doing something to tackle in a constructive manner, which seems to produce more peaceful results than the policy in the U.S.A., and the majority of the African population here seems happier than the Negroes in the U.S.A. It would, possibly, surprise Dr. Stafford-Clark to find how many of his potential black protagonists of an alleged civil war are in fact very much in favour of the changes brought about by the present Government, especially in the Transkei, and also how peaceful life is here. I notice that Dr. Stafford-Clark has no criticism of other African States, which have one-party Governments, or practise detention without trial as in Kenya, Ghana and other countries. Nowhere else on the Continent has the African such a high standard of living as in this country.

The people detained in South Africa are treated in this manner for a definite reason and all have been warned beforehand to break their Communist associations. The same happened in England during the war, except that some spies

were shot. If he is in sympathy with Communist-controlled States, I can understand his point of view.

I feel that before outsiders start criticising, they should be sure of all facts and speak from personal experience rather than from the biased views they have culled from newspapers.

May I, in closing, quote two typical cases of the above that have come to my knowledge recently:

(i) A visiting Doctor from England came with a photograph from a left wing newspaper in England of "slave labour in South Africa chained to their work." While going down a gold mine on a Saturday morning, he saw the self-same "slaves" chained—mainly because they were doing maintenance work on a lift shaft with a 3,000 foot drop! The "slaves" were incidentally being paid overtime for this work, as they normally work five days only.

(ii) A patient of mine from Rhodesia, four years out from England, showed me a newspaper photo from an English newspaper brought out by an English friend. The picture was of a dozen or so Africans lying on the ground in a park. The caption stated that these were dead Africans left unburied after a riot in Rhodesia. In fact, it was a photo of a park in the centre of Salisbury, where a great many Africans working in the city normally have an hour's sleep in the sun during the lunch-hour.

The *Gazette* is hardly a forum for political arguments, particularly by those ignorant of the true facts; surely Hyde Park on a Sunday afternoon is the right place.

I am very sorry that Dr. Stafford-Clark's heart is sinking; possibly if he were to visit South Africa he might learn something new.

Yours, etc.,

DR. J. A. L. LEEMING.

Medical Centre,
Johannesburg,
South Africa.

SIR,—It is with the same sense of profound and sincere regret that I answer Dr. Stafford-Clark's (well-meaning, no doubt, but self-righteous, misinformed and unintentionally mischievous) letter, damning not even with faint praise South Africa, its policies and its people holus-bolus.

What Imperial Western country in its long history of wars, incursions, and annexations, has less blood on its hands than South Africa? I spent many happy years and made many friends (amongst them a Siamese, an Indian, a Jamaican and a Chinese) during my student and houseman days in the period 1927-1939, in the England that still remembered with pride its forays against the "wogs" and "fuzzy-wuzzys" of Africa, and the Boers; that glorified in its literature, its gunboat diplomacy against the Chinese, the Arabs and the Indians, etc., etc.

Neither was the England of my time free of its social contempts, injustices and prejudices.

The descendants of the Boers, rightly or wrongly, still remember with much bitterness, the bannings, the deportations and exiles to St. Helena, and the iniquitous concentration camps and the burning of farms against which the English Emily Hobhouse campaigned so vigorously. (Incidentally gold and diamonds had just been discovered.)

We, too, have our Emily Hobhouses; a large proportion of the population dislikes unjust laws and intolerance.

The time I was at Guy's and Moorfields was the time also of the rise of Hitler and all his beastliness. It was also the time of the rape of Abysinnia by Italy; it was the time of the Spanish Civil War, etc., etc. A few fine Englishmen like Crossman and van Sittart were angered and indignant; but did a vast mass of Englishmen rush in and risk a certain and bloody death or worse, in the early or middle 30's? Was the final show-down of 1939 (or for that matter the 1914, or the Boer wars) etc., inspired entirely by motives of morality and idealism, or did perhaps trade and self-preservation not play some little part?

Would Dr. Stafford-Clark expect the same of those of us in this country who oppose extremist policies, to do what he did not do in the 30's? Did he rush off to Spain and enlist with the International Brigade for instance?

Sir, I enclose a very recent cutting from our local paper which you might show to Dr. Stafford-Clark and perhaps even pin on the notice board of the Spit. Dr. Stafford-Clark's type of well-bred and law-abiding opposition to extremism is not dead in this country either, as you can see. On the other hand, whatever the shortcomings of those now in power, we can at least be grateful in these confused times (and with a chaotic Africa elsewhere), that we have a strong Government that is determined to prevent bloodshed, or refuses to bow down to the vociferous and self-seeking in other parts of the world. Another thing can be said in its favour—it has never meddled in any other country's affairs.

Sir, the more decent people that we can get in this country such as dentists and doctors from Guy's, perhaps the less will be our "sheer moral cowardice" and "the continuation of a monstrous evil and injustice."

Armchair critics will solve none of our or the world's difficult problems.

Yours, etc.,

C. J. BLUMENTHAL.

28, St. James Road,
East London,
South Africa.

SIR,—It was with profound and sincere regret that I read the letter from Dr. D. Stafford-Clark in the *Gazette* of 9th July.

Whilst his opinions were no doubt honest, he obviously has been sadly misinformed on South Africa.

No country in the world has done more for its under-privileged people, no country has more freedom within the law. Of course if one "kicks dad in the teeth", one expects some disciplinary action!

Suggest the beams had better be removed first! N.H.S., strikes and international "bad debts"!—for a sample.

Yours, etc.,

F. FISHER ROBSON.

324, Robinson House,
Union Avenue,
Salisbury,
Rhodesia.

SIR,—May I earnestly request that matters of international politics be not debated in the *Gazette*. Dr. Stafford-Clark's letter in the July 9th edition puts forward the well-known views of the Left. Those of us who are refugees from British Socialism do not necessarily agree with these views, which also receive much publicity in other journals and news media. This is not to suggest that we are not in sympathy with the desire to improve the lot of all peoples, in Africa and elsewhere. However, we must remember that there is stable government in South Africa and a higher standard of living and education, and therefore of hope for progress, than in any of the "free emerging nations" in the rest of chaotic Africa. Today I hear that Mr. Wilson and his party are passing laws to prevent Britons from listening to broadcasts not under their own control (and presumably censorship).

Britain has come a long way from Magna Carta—but not always in the right direction. Please, sir, realising that men of goodwill can differ greatly in their views on politics and have very strong feelings, will you keep politics out of the *Gazette*.

Yours, etc.,

DONALD PAINE.

Medical Arts Building,
539, Cassells Street,
North Bay, Ontario.
Dial 472-6950. 472-0625.

NOTICE

Missing Copies

Over the years we have lent many Offprints from Scientific American and Xerox copies of reprints to Second M.B. students. Only a proportion of these and of the thermometers given out by the Department have been returned. It would be a help if those students knowing that they have such items would return them to the Department before the beginning of the new academic year.

J. N. HUNT.

REVIEWS

AN INTRODUCTION TO GERIATRICS. *Bernard Isaacs.* Baillière, Tindall and Cassell. 30s. Pp. 212.

This is a very enjoyable book. Dr. Isaacs starts by asking "What is geriatrics?" in an illuminating introductory chapter. By the end of the book, the reader has a clear insight not only into the clinical and social problems of old age, but also into the orientation of a geriatrician towards his work.

Despite a selective treatment of the subject, the bold emphasis of important details in management of disability and sickness portrays a clearer picture than might be gained from a systematic text book. The freshness of the author's approach clarifies many vague subjects. His witty aphorisms clearly imprint on the memory some of the special points in history-taking and examination of the elderly. Rehabilitation is essentially teamwork—the physician is the co-ordinator, and the ward discipline is the basis on which the patient's ability is assessed and improved. The importance of an accurate diagnosis is stressed and illustrated by a large number of remedial conditions.

Geriatrics is also concerned with the lives of old people after they leave hospital. The chapters on community facilities and government and local authority services are helpful, and the description of social conditions of old people throws light on the complexities of family structure.

The book is well produced, and there is a useful bibliography and index. As a mine of information, clinical observation and common sense, it is cheap at the modest price.

J. ROSIN.

PRINCIPLES OF X-RAY DIAGNOSIS OF THE SKULL.

by G. H. Du Boulay, London, Butterworth, 1965. pp. 370. £7 10s. 0d.

This monograph, which is of large size and copiously illustrated, is really designed for consultant radiologists and for those clinicians who are interested in neuroradiology, rather than for students or registrars. The 640 illustrations are well chosen and of almost life-size, but the quality of reproduction is not always as good as desired. These illustrations depict the whole gamut of radiological pathology in the skull including the temporal bones and accessory nasal is the importance of high quality radiography. However, "coned views" are sinuses. Technical points such as "high definition" screens are emphasised, as scarcely mentioned, while tomography is briefly dealt with.

The text accompanying the illustrations is simple and straightforward. There is an extensive bibliography at the back, but cross-references are not mentioned in the text. This has been purposively done in order to make the text less cumbersome, but the reviewer thinks this is a pity for much preliminary knowledge on the part of the reader is required before the text and the illustrations can be properly appreciated. This monograph is really a book of reference, and as such can be recommended.

M. A. FALCONER

DENTAL EDUCATION

by

A. R. Ten Cate

The World Health Organization's technical report (No. 244) on Dental Education lists among the objectives of dental education "(1) the attainment of a high level of general education, (2) a thorough understanding of biological sciences and (3) a knowledge which will allow the dentist to appraise research findings critically and apply them to his own practice". The report goes on to recognize "the need for a scientific basis to dental practice and that the emphasis should be on principles rather than details". It also states that "although there is general agreement as to the importance of a broad outlook in the teaching of the biological sciences, the ultimate value of such teaching must be judged by their contribution to a well-correlated course of studies in dentistry. A sharp demarcation between preclinical and clinical teaching is artificial and, to a certain extent, prejudicial to a well integrated course". These views are probably too idealistic if at the same time sufficient dental surgeons are to be provided to satisfy the national demand. However, it is instructive to outline the pre-clinical course provided for the dental student at Guy's and to see how closely this matches up to the aims and objects set out in the W.H.O. report.

At the present time the dental student has one academic year to acquire a detailed knowledge of the anatomy of the head and neck, some knowledge of the abdomen and thorax and the essentials of neurology, histology and embryology during the course of his anatomical studies. At the same time he receives courses of instruction in physiology and special dental anatomy which includes comparative anatomy, dental embryology, dental histology and oral anatomy. Added to this there are lectures in biochemistry (generally regarded by the student as superfluous because there is no examination in this subject) and forty hours of tooth carving to test his practical ability. It is little wonder that the student suffers from factual indigestion in his first year; that he often fails to grasp essential principles, and that this factual information is rapidly forgotten once it has been regurgitated for the benefit of his examiners. He has little time to read, ponder, and criticise and his teachers have little opportunity of stimulating interest in their particular subject. Remember also that the first few weeks of the academic year are, for the new undergraduate, a settling-in period

and the last few weeks are used for revision before his professional examination. In this short time it is virtually impossible to inculcate scientific principles and develop a critical faculty which the average undergraduate can later apply during his clinical training. Another drawback is that in many Schools the pre-clinical subjects, apart from special dental anatomy, are taught by medically orientated teachers often unsympathetic to the needs of the dental student. It is to the credit of this School that posts of anatomy and physiology in relation to dentistry have been created and filled by dentally qualified staff with anatomical or physiological qualifications.

With the curriculum outlined above, with the relatively short pre-clinical year and with the adverse staff/student ratio (2/80 in special dental anatomy) it is difficult to see how the objectives set out in the W.H.O. report can be achieved. Accepting the facts that (1) there can be no extension of the pre-clinical year, (2) that large student numbers will persist (but not, it is hoped, the adverse staff/student ratio) and (3) that a high percentage of the undergraduates have no academic pretensions and are only desirous to obtain information necessary to practice dentistry, some re-organization of the pre-clinical year is necessary. First, there should be some contraction in the instruction of anatomy and physiology. Second, in my opinion tooth carving should be eliminated from the pre-clinical year. In anatomy, about which I can write with some knowledge, the elements of embryology, histology and neurology as taught at present cannot suffer further contraction, nor should there be any contraction in the time spent teaching special dental anatomy. Some time could be saved in the teaching of the detailed topographical anatomy of the head and neck. Detailed knowledge is only really required of the oral and para-oral structures. If we assume a minimum of ten hours each made available from both the anatomy and the physiology courses and a further forty hours from the abolition of tooth carving, a total of sixty hours is saved in the academic year. Although some anatomists and physiologists may carp at any contraction of their teaching time any loss will be more apparent than real. The time saved will be used, as outlined below, to introduce the student to principles of biostatistics, biochemistry and cell biology which are at present touched upon by the anatomists and physiologists in relation to their own subjects. There is no doubt in my mind that a large proportion of this additional time should be allotted to the teaching of biochemistry. How many students in their later clinical training really understand the mechanisms of salivary secretion, plaque formation, fluoride metabolism, calcification and even caries, because of their lack of biochemical knowledge? In addition, short courses, of say five lectures each, on the principles of biostatistics and cell biology should be included in the pre-clinical year if only to focus attention on these subjects. It is a sorry reflection on the undergraduate that, if these courses suggested above are to have any value, they must be followed by some form of examination.

The character of the professional examination must therefore be altered to accommodate the proposed changes in the curriculum. This does not necessarily involve the writing of additional papers as these subjects could be included in the framework of the examination in its

present form. For instance, compulsory biochemical questions could well be included in the physiology examination. A criticism that could be levelled at this proposed pre-clinical course is that the student will still suffer from factual indigestion. He may do so, but maintaining a realistic approach and recognising that the vast majority of the student body are not academically inclined, it is doubtful whether further free time would be used for reading more widely and for developing a more critical judgment. In conjunction with the suggestions outlined below the proposed course will achieve at least two objectives, it will provide most students with some inkling of scientific principle and, for the few more academically inclined in any year, will serve as a springboard for additional studies in the biological sciences.

There are two essential adjuncts to this proposed scheme. First, that the emphasis placed on the biological sciences in the pre-clinical year be maintained in the first clinical year. It is necessary to extend the principles taught in the first year in the teaching of microbiology, the principles of pathology, pharmacology and with clinical practice. These subjects must be taught early in the period of clinical training so that the student can observe how scientific principles apply to the practice of dentistry. Such a step would also go a long way to abolish the barrier between clinical and pre-clinical studies which exists in the students' mind. It could be argued that this should be achieved in the first year, but my own opinion is that applied aspects of anatomy, physiology or biochemistry mean little to the student at this particular time in his studies.

The second adjunct must be a provision for the academically inclined dental undergratuate to continue his education, if he so wishes, in the biological sciences. At the present time there is some provision for such a student to continue his studies and take the 2nd M.B. examination and then read for a special B.Sc. degree in Anatomy or Physiology. However, with the present relaxation of the B.Sc. regulations there is a danger that the opportunity for the dental undergraduate to read for a B.Sc. degree will be overlooked. It is essential that the opportunity for the academic dental undergraduate to read for a degree in the basic sciences be maintained if dentistry is to progress in the future. One can go further and argue that as dentistry is considered worthy of degree status, to be read rather than practised for, provision should also be made for the establishment of a degree course in Dental Science.

Here at Guy's the facilities almost exist for the establishment of such a degree course. The Departments of Biology, Physics, Chemistry, Anatomy, Physiology, Pathology, Pharmacology, could, between them, offer sufficient course units to satisfy University requirements. Therefore, to conclude this article and to provide some thought for discussion a tentative course of study is outlined for such a degree (Fig. 1). It may be impracticable at the present time and it has its drawbacks, but it is offered as a skeleton on which to build.

In the first year all dental undergraduates would read for their second professional examination. After this the majority will continue

with their clinical studies, but a few with the necessary intellect (plus possibly selected undergraduates from the other Schools and also some graduate dental surgeons) will continue with a two-year course of study leading to a degree in Dental Science.

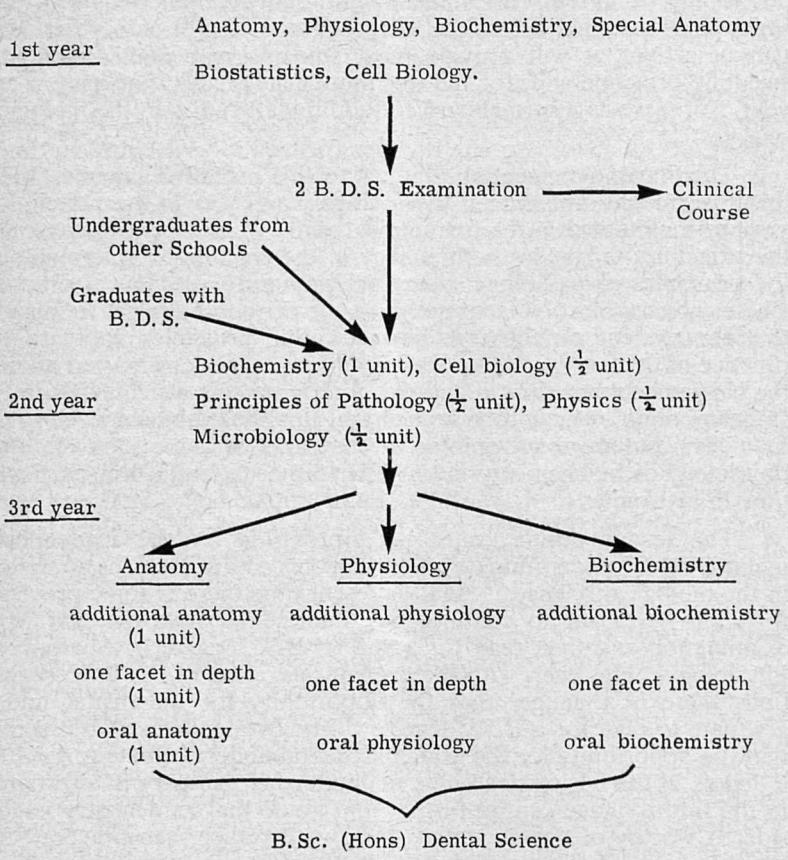


FIG. 1.

In the second year of the dental science course instruction should include additional biochemistry (1 unit), cell biology and the principles of pathology (½ unit each), physics with the accent on the properties of materials and aspects of metallurgy (½ unit) and finally microbiology (½ unit), making a total of 3 course units for the year. In the third and final year one would ultimately like to see the undergraduate offered a choice of three streams providing either an anatomical, biochemical

or physiological bias. To illustrate this, suppose the undergraduate has a preference for anatomy. One course unit would comprise further anatomical studies in some of the fringe subjects such as anthropology, comparative anatomy or embryology. The second would be the study of one facet of anatomy in depth, preferably a topic which is being extensively investigated in the department. The final course unit would be the study of dental anatomy. In the preceding few sentences biochemistry or physiology can be readily substituted for anatomy to give an outline for the alternative streams.

At the completion of this degree course the graduate can call a halt if he so wishes. Alternatively he can continue with his clinical dental studies and read for the B.D.S. degree. It would be ideal if the clinical training of those already in possession of a first degree could be abbreviated, possibly by six months, but this does not come within the scope of this article and will not therefore be discussed.

NURSING SECTION

The Nurse's Best Friend

Why can't medical students be more conscientious in finishing off the details attached to their work?

In years gone by the majority of dressings were carried out by the Surgical Dressers, and the Ward Clerks took a much bigger part in carrying out investigations on their patients. With changes in the education of students, it is appreciated that more of their time is spent in operating theatres and clinical lectures and classes.

There are a number of students who are interested enough in their work to go to great lengths to watch and take a big part in the treatment of their patients.

However, the majority of medical students today appear to do the minimum amount of work and leave a trail of mess behind to be cleared up—presumably by the overworked nurses. Rubbish is left in the most extraordinary places—one ward sister found a pile of matter left from venepuncture by a student in the bag containing her stores commodities which was standing by her desk! Syringes are unwashed and E.S.R. tubes are recording the E.S.R. over a fortnight for some lucky patient. These conditions are exasperating for any nurse, and when she has to take time from nursing the patients to clear up the mess, then there obviously needs to be an improvement here.

Students are constantly complaining about their treatment by the nursing staff. Some of these complaints may be justified, but they are motivated by the irresponsible habits of their colleagues. It takes only two minutes longer to clear away equipment and leaves a more peaceful and congenial atmosphere behind the scenes in any ward.

Perhaps a short compulsory pre-clinical talk and explanation would go a long way in helping medical students to keep on good terms with the nursing staff.

The following Nurses have passed the Final State Examination held in June, 1966:—

Alexander, H. M.
Algore, S. R. I.
Atkins, P. C.
Baillie, J.
Barrett, A. A. M.
Barry, H. J.
Beynon, E. H.
Blackmore, W. L.
Bowers, G. S.
Burr, M.
Burton, M.
Carruthers, S. M.
Chapple, M.
Craven, J. L.
Crawley, C. M.
Dutton, H. R.
Evans, S. M. M.
Finlay, M. J.
Fleming, J. M.
Fraser, B. H.
Fryer, C. A.
Gardner, R. J.
Gough, A. Y.
Greaves, S.
Greenwood, E. M.
Griffiths, M. W.
Hale, C. G.
Harris, J. M.
Hetherington, J. M.
Hill, A.
Howes, P. A.
Hughes, J. M.
Hunter, C.
Jones, W. P.
Lambert, J. M.
Lee, M. V.
Lyth, J. A.
McFarland, S. E.
Mackenzie, S. M. G.
Millner, E. J. B.
Moffat, V.
Morgan, H. L.
Norris, S.
O'Connell, S. M.
Parker, P. E.
Pavitt, L.
Rees, M. V.
Reffell, Y. D.
Rivett, S. M.
Roberts, N. E. R.
Rogers, C. O.
Rose, V. C.
Rushforth, M. A.
Sirett, J. M.
Stanbury, S. A.
Taylor, J. R.
Thomas, M. F.
Tomlinson, J. M.
Vanson, C. J.
Ward, J. L.
Webb, M. M.
Whitaker, V. M.
Williams, G. C.
Williams, J. N.
Yorke, E. M.

Combined training with Moorfields Eye Hospital, E.C.1.

Boucher, R. A.
Rees, J. V.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister R. Brayford to Administrative Relief Sister, Matron's Office.
Sister A. Frost to Administrative Sister, Matron's Office.
S/M A. Awuah to Victoria Ward.
S/N G. Cawthorne to Christopher Ward.
S/N E. Chandler to Evelina Children's Hospital.
S/N A. E. Oxley (née Wilton) to Outpatients Department.

DEPARTURES

S/N S. M. M. Evans from Night Duty.
S/N C. F. Fincham to continue Psychiatric training scheme at Bexley Hospital.
S/N L. Jacob from Night Duty.
S/N C. de Mierre from Outpatients Department.
S/N L. Payne from Job Ward.
S/N C. E. M. Taylor from Casualty.
C/M G. Walsh from Nuffield D. Floor.

SPORT

This time of the year is probably the slackest as far as competitive sport at Guy's is concerned; the Cricket Club have only one more fixture, the Tennis Club only two. On the other hand, the organisation for the coming winter is progressing well.

The Cricket Club's main interest at present is whether Jo Butchey can reach his thousand runs for the season or not. Prior to the tour, it looked almost certain that he would, but, with bad weather and bad luck both on the tour and since, he needs 30 odd more runs in Guy's last match on Saturday against Old Alleynians. To score a thousand runs in club cricket is a very fine achievement, particularly at Guy's, where the season ends far earlier than at other clubs. One needs luck with the weather as well as with the bat, and whether Butchey reaches the target or not, an aggregate of so many runs is a fine example of consistency, and application to the job in hand.

J. Newman, the secretary of the Tennis Club, has won the Club's Championship, after defeating H. C. Sharp, the club captain, in the semi-final.

The Rugby Club have been invited to partake in the Cheltenham R.F.C. Sevens Competition on Sunday, September 18th. The sixteen teams competing include some of the local Gloucestershire sides, and other visiting sides such as Moseley, Harlequins and Liverpool.

On the following Sunday the club is to be represented in the Streatham and Croydon sevens. Unfortunately in the first round, Guy's have been drawn against Northampton, who were a guest side in the Middlesex sevens at Twickenham in April, where they played fairly well in reaching the semi-final.

In the 1st XI's penultimate game last Sunday, Guy's were heavily defeated by London New Zealand. Guy's batted first to score 173 for 8 declared, with Clark 93 not out, leaving the opposition 130 minutes to score the runs. Unfortunately they won by 9 wickets with twenty-five minutes to spare, thanks mainly to a fine century by one of their openers, who was only dismissed when the scores were level.

DIARY

CRICKET.

August: Sat., 20th—Old Alleynians. Away.

TENNIS.

August: Mon., 22nd—Lloyds Bank. Away.
Sat., 27th—Tunbridge Wells. Away.

REPORTS AND RESULTS

CRICKET

GUY'S HOSPITAL CRICKET CLUB TOUR, 1966

JULY 29th—AUGUST 4th

We left Guy's on the morning of Friday, July 29th, bound for Basingstoke. We agreed to stop for Lunch at a pub recommended by an experienced tourist 10 to 30 miles outside Basingstoke. Needleless to say, we all had lunch at different places and congregated at the Basingstoke ground. The weather was bad and the pitch was wet, and fearing that the game might not be completed we elected to bat on winning the toss. Butchey, in sight of his thousand runs for the season, was out in the second over, trying it seemed to achieve his target in one stroke. Silk and Gillham moved the score slowly along, until at 57 the latter was bowled. Some sensible batting by Swift (40), well supported by Griffiths and Davoodbhoy, enabled us to declare at 154 for 7 at 5 o'clock. Basingstoke started slowly. One of their openers, reputed to have considerable county experience, made a faultless 13 in the first hour. However, his brother, coming in at number

three, was quite the opposite. He hit the ball very hard, and with support from numbers four and five, they were able to overtake our total with three minutes to spare.

We left Basingstoke at 9 p.m. for our usual rendevous at Selbourne. The session here was as good as usual, and we all set off by devious routes to Thatchings at Bognor.

This year, owing to the recent illness of Mr. Lewis, we unfortunately were unable to stay at Thatchings for the full week; we stayed for the first three nights—no meals provided, so we found ourselves in quest of food on Saturday morning. We finally landed up in a large seaside cafe in Bognor which we patronised every morning.

After breakfast on Saturday, half of us met at the "Ship". Here followed an amusing session, and after we had drunk a prodigeous number of G.T.'s and eaten a round of sandwiches each, we drove over to play Littlehampton.

After making sure that the opposition had a television set in their pavilion so we could watch the World Cup, the captain was sent out to toss with express instructions to win and elect to bat. However, true to form, we lost it, but were surprisingly, in the circumstances, put into bat. It is customary at Littlehampton for us to reverse the batting order; so it was with more attention than usual that we watched Beacham and Turfitt go out to bat. The latter was thought not to be in prime condition. Presumably through an urge to watch the world cup, Guy's were soon in trouble, and we lost three wickets for only five runs. Some unexpected solid batting by Carruthers rallied the side, and Crafts and Swift, both batting extremely well, enabled us finally to reach 161. Meanwhile everybody had enjoyed seeing England win the World Cup. Beacham and Turfitt opened the bowling and soon had dismissed the first three batsmen. Appleby and Pierson were then brought on; the former flighting the ball characteristically, claimed four victims. Littlehampton, only fielding 10 men, were bowled out for 79, a poor performance in any circumstances—Gillham claiming the last wicket, bowling probably the first over of his career!

We arrived at the Bognor ground on Sunday morning after a good night and a good breakfast, feeling, I think, somewhat worse for wear than in previous years at this stage. The wicket was slightly green, and on winning the toss we elected to field. Harris, the Bognor opener, tried to hit Beacham's first ball through the covers for four, and was effortlessly caught by Davoodbhoy at 2nd slip. Beacham continued to bowl well, supported ably by Clark, who had the other opener caught behind with the score at 34. Davoodbhoy was then brought on, and put up his best performance of the season—his analysis reading 26 overs, 6 for 30. Bognor were dismissed for 129, not before an interesting last wicket partnership of 25 had been defeated. Guy's started badly, Butchey being out early on with the score at 17. Clark, Silk and Appleby followed in succession; it was Griffiths who scored 40, backed up by Swift and Crafts, who eventually saw us home by three wickets. After a good performance in the field we put up an even better performance in the bar afterwards, well supported by a colleague from Brighton Hospital who, we were told, had an interesting drive back afterwards. We were all seen to leave the pavilion sometime after 12.30, having thoroughly enjoyed our day with Bognor.

After our usual meeting at the "Ship" on Monday morning, we drove over to Faring. It started to rain when we arrived and the wicket was extremely wet. It was with regret that this match was finally called off. After leaving we all went our different ways, agreeing to meet at Cuckfield on Thursday.

On Thursday we all arrived at the ground around 11 o'clock, three members of the team having camped at Bognor in weather more suited for other occupations. The pitch was extremely wet, and no play was possible before lunch. We all went up to the local to watch the test match and have a few drinks before lunch. Here our renowned opening batsman from the Littlehampton match decided to show us how to drink, and he was probably the only relieved player when the rain came just before lunch. It was very disappointing to see our last game of the tour called off, which brought the ending to a tour which had been marred by rain.

Results:

Friday, July 29th—v. Basingstoke, 2.30.
Guy's: 154 for 7 declared.
Basingstoke: 155 for 4.

Saturday, July 30th—v. Littlehampton, 2.30.
Guy's: 161 for 9.
Littlehampton: 79.

Sunday, July 31st—v. Bognor, 11.30.
Bognor: 129. (Davoodbhoy, 6 for 30.)
Guy's: 130 for 7.

D. B. A. SILK

LAWN TENNIS

Final of Inter-Hospitals' Cup
GUY'S v. LONDON

At H.O.P. 25th July, 1966

The London Hospital 1st pair unfortunately arrived late and so only two matches were played in the first round. Swiss and Hughes gave Guy's a splendid start by thrashing the London 2nd pair 6—2, 6—0, and Hopkins and Newman put Guy's 2—0 in the lead by beating their 3rd pair, which looked suspiciously stronger than their 2nd. In the 2nd round against respective pairs, Sharp and Machell quickly beat their opponents, but the other pairs put up more resistance. Hughes and Swiss lost the first set to the opposition 3rd pair but pulled back to win in the final set. This left Hopkins and Newman playing against London 1st pair to clinch the match. After an uncertain start, which necessitated saving two set points, the Guy's pair improved and finally won 7—5, 6—4 to secure a winning 5—0 lead. The match result having already been decided, the 3rd round was played light heartedly making the final score 6—2 to Guy's.

This is the 14th time Guy's have won the tennis cup in the 19 times it has been played since the war. Most of the team should be here next year, so let's hope Guy's can maintain their superiority.

		1st	2nd	3rd
J. Hopkins	..	W 7—5	W 7—5	W 6—1
J. H. Newman	..	6—4	6—0	6—3
H. C. Sharp	..		W 6—4	L 1—6
R. Machell	..		6—1	6—3
				3—6
P. Swiss	..	L 3—6	W 6—2	W 4—6
R. A. C. Hughes	..	1—6	6—0	6—3
				6—3

J. H. NEWMAN

National Provincial

The Guy's Hospital Office, which is opened for your especial use, is under the management of Mr. A. C. Edwards, Southwark Branch, 10-14, Southwark Street, London, S.E.1, and enquiries will be welcomed.

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HOSPITAL INFORMATION

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy as **Senior Registrar in Clinical Pathology to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board,** for the period 7th November, 1966, to 30th September, 1970. Applicants will be expected to spend two years in a Regional Board Hospital on an exchange basis during the tenure of the post. The appointment will be made jointly by the bodies concerned, and will be held in the first instance at Guy's Hospital. The post in the Regional Hospital will be held in the Lewisham Group. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales).

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **30th August, 1966.**

BOARD OF GOVERNORS OF GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Registrar in Psychiatry

Applications are invited for the above post, to be held jointly at St. Olave's Hospital, S.E.16, and Bexley Hospital, Kent. The Department of Psychological Medicine at St. Olave's Hospital offers in-patient, day patient and out-patient facilities in a busy general hospital. Opportunity will be provided for study and experience in developing community service involving links with Guy's Hospital. Experience in special problems and rehabilitation will be provided at Bexley Hospital which is a modern adult psychiatric hospital.

Candidates may be resident or non-resident and should have previous psychiatric experience. Appointment from 8th November, 1966, to 30th September, 1967.

Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **30th September, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar to the Dialysis Unit,** with duties commencing 1st October, 1966, and appointment for one year in the first instance. Forms of application are obtainable from the Superintendent, and should be returned not later than **31st August, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the following appointments, to commence duties 1st October, 1966, or as soon thereafter as possible:

Department of Minor Oral Surgery
Registrar to attend on three sessions per week.

Department of Dental Prosthetics
Registrar to attend on two or three sessions per week.

Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Saturday, 3rd September, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Locum Registrar in Clinical Dental Surgery** (including Oral Surgery), to attend full-time for the period of October and November, 1966. Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, London, S.E.1, not later than **Saturday, 10th September, 1966.**

Guy's Hospital, S.E.1, requires **Dental Surgery Assistant,** for duties mainly in the Dental Department for Children. Whitley Council salary and conditions of service. Write immediately to Administrative Officer, Dental Department.

GUY'S HOSPITAL MEDICAL SCHOOL, S.E.1.

Applications are invited for (a) **the Astley Cooper Studentship** tenable at Guy's Hospital Medical School. The Student, who is the Astley Cooper Assistant to the Curator of the Gordon Museum, will be elected for a period of three years, the salary being approximately £150 per annum; (b) a post of **part-time Assistant to the Curator of the Gordon Museum,** salary £150 per annum. Applications should be made on a form obtainable from the Dean, Guy's Hospital Medical School, S.E.1.

GUY'S HOSPITAL, S.E.1.

A ten-month training course for female Dental Hygienists will commence in April, 1967. Candidates must be at least 17 years of age and should have obtained a minimum of four G.C.E. subjects at "O" level. Application forms, which should be submitted by **Friday, 8th October, 1966,** may be obtained from the Department of Preventive Dentistry, Guy's Hospital, S.E.1.

HOUSE APPOINTMENTS

GUY'S HOSPITAL

September 1st, 1966

Assistant House Surgeons

To:
Mr. Lawrie — Mr. C. C. Penney
Appointed for 6 *months, the first* 3 *as A.H.S.*
Mr. Glover — Mr. C. A. Soutar
3 *months*
Mr. Brain — Mr. R. O. Robinson
Appointed for 6 *months, the first* 3 *as A.H.S.*
Mr. Beard — Mr. R. C. Day
Appointed for 6 *months, the first* 3 *as A.H.S.*

Assistant House Physicians

To:
Dr. Mann, Dr. Scott and Dr. Bishop — Mr. G. A. Machin
Appointed for 6 *months, the first* 3 *as A.H.P.*
Dr. Hardwick, Professor Trounce and Dr. Deuchar — Mr. R. B. Stott
Appointed for 6 *months, the first* 3 *as A.H.P.*
Dr. Baker, Dr. Houston and Dr. Grimble — Mr. J. M. Boulton Jones
Appointed for 6 *months, the first* 3 *as A.H.P.*
Dr. Kauntze and Dr. Joiner — Mr. M. E. French
Appointed for 6 *months, the first* 3 *as A.H.P.*
Professor Butterfield and Dr. MacLean — Mr. J. M. Richards
3 *months*

Casualty Officers

Mrs. I. M. J. Mathias
Mr. M. E. Pembrey
Miss L. M. Rikard-Bell
Mr. R. A. J. Spurrell
Mr. H. J. Sturzaker
Mr. D. Tong
— 3 *months*

House Surgeon to the Surgical Unit

Mr. D. G. Gourley
3 *months*

House Surgeons
To:
Mr. Eckhoff — Mr. T. N. D. Peet
3 *months*
Professor Atkins — Mr. M. H. Jourdan
6 *months*
Mr. Wass — Mr. W. T. Lamb
3 *months*
Mr. Blackburn — Mr. T. H. Guerrier
6 *months*

House Physicians
To:
Dr. Mann, Dr. Scott and Dr. Bishop — Mr. M. S. Vernon
3 *months*
Dr. Hardwick, Professor Trounce and Dr. Deuchar — Mr. P. A. D. Williams
3 *months*
Dr. Baker, Dr. Houston and Dr. Grimble — Mr. D. J. Hendrick
6 *months*
Dr. Kauntze and Dr. Joiner — Mr. P. C. Pietroni
6 *months*
Professor Butterfield and Dr. MacLean — Mr. J. D. Rogers
3 *months*

Resident Obstetricians
Mr. A. J. Robson
3 *months*
Mr. S. M. Wood
6 *months*

Gynaecological House Surgeon
Mr. P. Bowen-Simkins
6 *months*

Throat and Ear House Surgeons
Mr. C. E. M. Lamb
3 *months*
Mr. D. B. Mathias
6 *months*

Neurological House Physician
Mr. G. A. Pettitt
6 *months*

Orthopaedic House Surgeons
Mr. C. A. C. Pickering
3 *months*
Mr. G. Smith
6 *months*

Dermatological House Physician
Readvertised
6 *months*

Genito-Urinary House Surgeon
Mr. J. G. Cochrane
3 *months*

House Surgeons to the Thoracic Unit
Mr. D. H. Evans
3 *months*
Mr. J. R. W. Keates (S.H.O.)
6 *months*

Children's House Physicians
Mr. B. S. Ricketts
3 *months*
Mr. A. W. J. Medhurst
6 *months*

House Physicians in Clinical Pathology
Mr. B. Read (S.H.O.)
3 *months*
Miss J. Parker (S.H.O.)
3 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur
Mr. L. D. Byer
6 *months*

House Physician in Child Psychiatry
Mr. B. H. Anstee — 1.9.66—30.9.66

House Physicians in the Department of Psychological Medicine
Mr. P. Nott — 1.4.66—30.9.66
Mr. K. Standage — 1.4.66—30.9.66
Mr. S. Bhanji — 1.10.66—31.3.67
Mr. B. H. Anstee — 1.10.66—31.3.67

R.M.O.s in Nuffield House
Mr. J. Macleod — 1.7.66—31.12.66
Readvertised — 1.9.66—28. 2.67

Resident Anaesthetists
Mr. M. B. Barnett
3 *months*
Mr. P. J. G. Baxter
3 *months*
Mr. D. J. Openshaw
6 *months*
Mr. I. A. Sutherland
6 *months*

Children's House Physicians at the Evelina Hospital
Mr. J. H. T. Marshall — 1. 4.66—30. 9.66
Mr. S. C. Mehta — 1. 6.66—30.11.66
Mr. J. C. Robertson — 1. 8.66—31. 1.67
Mr. J. R. T. Gabriel — 1.10.66—31. 3.67

Casualty Officer at the Evelina Hospital
Mr. B. G. R. Neville
6 *months*

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House Physicians to Dr. Mason and Dr. Cox:
Mr. J. S. Gregson — 1.7.66—31.12.66
Mr. D. L. Ingram — 1.7.66—31.12.66

House Surgeon to Mr. O'Flynn:
Miss H. Hale
3 *months*

House Surgeon to Mr. Lewys Lloyd:
Mr. P. Zelas (S.H.O.)
3 *months*

Gynaecological House Surgeon:
Mr. B. W. Hackman (S.H.O.)
6 *months*

Casualty Officer:
Readvertised (S.H.O.)
6 *months*

NEW CROSS HOSPITAL
House Physicians in Medicine and Geriatrics:
Mr. R. A. Sturge (S.H.O.)
3 *months*
Mr. J. F. Searle
3 *months*
Mr. D. J. Simler (S.H.O.)
6 *months*
Mr. C. D. Eraut
6 *months*

Orthopaedic House Surgeons:
Mr. A. H. Mowbray (S.H.O.)
3 *months*
Mr. A. E. Raynes
3 *months*

S.H.O. to the Rehabilitation Unit:
Mr. R. N. Chatterjee

BECKENHAM HOSPITAL
House Surgeon: Readvertised

HITHER GREEN HOSPITAL
House Physician in General Medicine and Infectious Diseases:
Mr. S. Worthington

JOYCE GREEN HOSPITAL
House Surgeons:
Mrs. A. M. Birch
Readvertised
House Physician: Readvertised

LEWISHAM HOSPITAL
House Surgeon to Mr. Le Brun:
Mr. M. J. Lindop
House Physician to Dr. Gans and Dr. Llewellyn Smith:
Readvertised

PEMBURY HOSPITAL
House Surgeon: Mr. M. I. L. Joseph
R. J. CANN,
Acting Superintendent.
August 9th, 1966.

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CHANGES OF ADDRESS

J. A. Rycroft, Esq., 19, The Uplands, Kenton, Newcastle-upon-Tyne.

Miss A. I. Norman, The Sisters' Home, Funthay Hospital, Bristol.

Dr. Brice Pitts, 20, St. Jame's Avenue, Marden Ash, Nr. Chipping Ongar, Essex.

R. A. Lewin, 83, South Street, Bishop's Stortford, Herts.

Rev. Dr. I. Lewis, M.B., B.S., C.M.A., 16, Lincoln's Inn Fields, London, W.C.2. After the 24th August, the above address will be:—
Rev. Dr. I. Lewis, M.B., B.S., C.M.A., Dagat, Gondar, Ethiopia.

Dr. B. P. Griffin, Brockhall Hospital, Langhe, Nr. Blackburn.

Mrs. M. Holmes, Doubloon Cottage, Oakhill Road, Seaview, I.O.W.

BIRTHS

TRAFFORD.—On July 27th, to Helen (née Chalk, S.R.N.) and Dr. Anthony Trafford, of 14, The Upper Drive, Hove, Sussex, a son, Mark Russell.

HOLMES.—On June 4th, 1966, at St. Mary's Hospital, Newport, to Margaret Anna (née Harrison, S.R.N., S.C.M.) and Gordon Holmes, of Doubloon Cottage, Seaview, a daughter, Anna-Eugenie, a sister for Rupert.

MACREA-GIBSON.—On June 29th, at home, to Mary (née Monck-Mason) and Dr. Neil Macrae-Gibson, a son, Torquil Niall, a brother to Gavin and Catriona.

HAYLEY.—On July 18th, 1966, to Anne and David Hayley, a son.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS
FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2037

GUY'S HOSPITAL GAZETTE

PASSIM

Tower Block Go Ahead

In our correspondence columns this week we publish a letter from the Chairman of the Tower Block Building Committee that contains the long-awaited news that the Tower Block building programme has finally received backing from the Ministry of Health.

This is a highly significant moment in Guy's history, and much credit must go to all those through whose efforts the hospital has succeeded, even in these frozen times, in getting this essential building programme under way. Our readers are urged to refer back to Mr. Burfoot's letter in the *Gazette* of March the 20th last year to recall the breadth of vision and great deal of hard work that has gone into laying the plans for the hospital's development; it is excellent news to know that within a few years from now some more of these plans will actually become bricks and mortar.

This Week, Yes, But What About Next ?

So it's television à la verité. With a backdrop of the notorious obstetric woodwork, the young Guy's doctors faced a slowly awakening nation, following closely upon the brief interviews of the previous two evenings with a showing that displayed somewhat better control of a sensational (sic) interviewer. The latter gained his required newspiece and mass deference from the young doctors. But the young doctors spoke about underpayment, marriage, overworking and emigration—about their services being a package deal to an insatiable public. Can it be any wonder that public reaction will be minimal when at the same time Dr. Kildare is being offered no longer as single stories but as overworked and over-stretched serial episodes, all "by popular demand?"

The answer is obvious. Hire the Royal Albert Hall, divide the arena into three separate sections, perform a tense, understaffed operation in one, hold a two-hour-waiting-varicose-vein-out-patient

session in the next and do a cameo of a day in the life of a Young Hospital Doctor in the third. Sir Malcolm could, no doubt, be persuaded to conduct a popular last-night-at-the-proms in the background to complete the three-ring medical circus. Medicine à la *verité* would bring in the bored winter crowds to such an extent that there would be medical *im*migration, and with luck the government would be baying from their box seats for some share in this massive money maker. If the obvious choice of Honourable Old Matrons for the enterprise were not Messrs. Wilson and Robinson the young doctors would then do well to consider a freeze (sic) on the payment of the special entertainment tax that will no doubt be instituted. (There is, of course, the other cheek waiting for the tongue, and if we may mix metaphores, what a lovely sound it would make if it were slapped when turned.)

Ah well, the life of a young hospital doctor is, we must remember, all bread and circuses.

Kestrels at Guy's.

From our Nature Correspondent:—

A pair of Kestrels appear to have nested in the tower of Hunt's House as fledged young have been seen and can be heard mewling most nights. This is a notable record as there are very few pairs in inner London.

Our two articles this week both merit some introduction. The first, on G.P. Obstetrics, is a challenging and fresh look at a very vexed issue of the present day. Mr. David Brown's solutions for Chelmsford, we feel, could be well applied throughout the country to the benefit of both the profession and the public.

The second article is a beautifully written account of nursing as it was by our much-missed Sister Falwasser. This article first appeared in the Nurses' League Journal but we are reprinting it here as we feel it deserves a wider audience.

We would like to offer our congratulations to Dr. Andrew C. Smith, Joint Senior Registrar at Bexley Hospital, for being awarded the Gaskell gold medal and prize by the Royal Medico-Psychological Association.

A BRIGHT FUTURE FOR THE G.P. OBSTETRICIAN

by

DAVID BROWN, F.R.C.O.G.

Director of the Chelmsford Postgraduate
Institute of Obstetrics and Gynaecology for G.Ps.

A closely co-ordinated obstetric community, pooling the contributions of the General Practitioner (G.P.) and the consultant obstetricians into a common-purpose obstetric service, should be the devoted aim of the country as a whole. Both the Ministry of Health and the Ministry of Education (in that it influences and finances doctors' education in obstetrics) should give the lead here. To achieve this they should insist that the spirit of "pulling-together" vibrates all throughout the maternity service. This should become a tradition and, to see that it is fulfilled, the idea must be inculcated into the medical schools—then continued in the residents' mess in all hospitals, all Maternity Liaison Committees, then finally it must become the avowed policy of the Ministry Maternity Committees.

In the Chelmsford area, a combined town and country district in mid-Essex, just outside greater London, a well-knit maternity service is operating. There are 75 G.Ps. and two consultants providing this, and of course they work in the closest harmony with the district and hospital midwives. The G.Ps. always make the decisions as to where the patients will be confined, and they have to choose between a G.P. Maternity Unit, the District, or the Specialist Obstetric Hospital and, furthermore, when a patient booked outside hospital develops any complication, it is the sole responsibility of the individual doctors to seek consultant advice or assistance. The routine of G.P. obstetrics is quite unsupervised by the hospital staff.

The Extent of G.P. Obstetrics in Chelmsford.

During the 6 years 1960-65 inclusive, there have been 22,627 deliveries in the Chelmsford area. Of these, as many as 11,713 (52%) were managed entirely by the G.P. obstetricians.

Table I.

Year	St. John's (Specialist Unit)	G.P. Units (3)	+	Home Confinements
1960	1,679=51.9%	644	+	909=48.1%
1961	1,801=52.9%	644	+	997=47.1%
1962	1,729=47.1%	769	+	1,170=52.9%
1963	1,786=48.0%	865	+	1,072=52.0%
1964	2,029=48.2%	963	+	1,192=51.8%
1965	1,890=43.2%	1,057	+	1,431=56.8%
6-year Total	10,914=48%	4,942	+	6,771=52%

It may be seen from Table I that the number of confinements managed by the G.Ps. is rapidly increasing, and that the greatest increase is occurring on the "District". It is unfortunate that the increase is not in the G.P. Units where equipment and facilities for improved obstetrics would permit the G.Ps. to practise much safer and more efficient midwifery. Regrettably, this will not be possible until more G.P. units are built, as the existing units are already overbooking the limited number of beds available to them. These G.P. units are well able to serve their immediate communities, even if their local population grows sharply, because of the enlightened attitude and willing co-operation from the Local Health Authorities in planning "early discharge" regimes. However, what is urgently needed is the construction of more small G.P. units, one in each of the towns which are not already so provided. After all, the National Health Service should see that *every* woman is supplied with *safe* and competent maternity care, no matter in which city, town or village she lives.

The Perinatal Mortality in Chelmsford.

Over the six years the perinatal mortality from 22,901 consecutive babies born has been **23.3/1,000 total births.**

Table II. Showing the trends.

Year	Babies delivered	Total babies lost	Perinatal mortality rate per 1,000 total births.
1960	3,268	103	31.2
1961	3,491	87	23.2
1962	3,717	72	19.3
1963	3,766	84	22.3
1964	4,237	105	22.4
1965	4,422	84	19.0
6-year Total	22,901	535	23.3

This figure is far below the National figure for England and Wales, even the 1965 National figure of 26.9/1,000 total births, and this is the lowest this country has ever known. Chelmsford's 1965 figure of 19.00 is also the lowest.

Quite clearly, these very satisfactory results could never have been achieved if the G.P. obstetricians had not played their complete role. Not only did they request that the greater risk patients be booked in the Specialist Unit in the first place, but they maintained a constant obstetric vigil with the patients booked in both the G.P. Units and the patients' own homes such that when unexpected complications appeared the patients were transferred to the Specialist Unit in sufficient time for the specialist obstetric services to have their maximum effect. And, of course, to bridge the distances between either a patient's home or a G.P. Unit and the obstetric hospital, the Flying Squad has played an ever-increasing part. To illustrate the improving efficiency of the G.P.'s early referral, there were only 7 babies lost outside the obstetric hospital in 1965—1 (only) in a G.P. Unit, and 6 on the "District".

The Satisfied G.P. Obstetrician.

There is little doubt that most of the G.P. Obstetricians in the Chelmsford area enjoy their maternity work, and without any question this contentment is to the advantage and welfare of the community they serve. Some of the reasons for this might be summarised:—

(1) The close **friendship and liaison** between the family doctors and the Hospital doctors.

(2) **The regular meetings held in the obstetric department.** For example, every G.P. is invited to lunch and a perinatal conference once a month. The attendance at these is between 25 and 40 on each occasion. Furthermore, the Specialist department is "open" to any doctor to accompany his patient who has developed a complication outside—and the doctor is encouraged to join the hospital team and play his full part in the subsequent treatment.

(3) By virtue of the **presence of a postgraduate institute of obstetrics and gynaecology** (unofficial so far) in the department, such that there are always at least two G.Ps. in residence (doctors from practices both from the United Kingdom and abroad), the members of the midwifery and medical staff are unaware of any hospital atmosphere that does not accept G.Ps. as members of the "team". It is therefore inevitable that the hospital staff's sympathy is always with the problems and anxieties of the local G.Ps. in the district.

G.P.Units are urgently needed and desired in many small but expanding towns by the Essex doctors and, of course, this great need is equally pressing throughout the country.

Preparation for entering G.P. Obstetrics.

It is now universally accepted that the two or three months of obstetric teaching undertaken as an undergraduate in a medical school serves no more than as an introduction to the subject. It is therefore not surprising that the concensus of contemporary obstetric opinion agrees that obstetric training should take place after graduation, when the young doctor is an obstetric house surgeon. The subject is essentially practical, so rendering it highly desirable that the academic and theoretical aspects of its intricacies should be learnt in parallel with the various practical techniques and surgical procedures. When choosing a suitable training post, a doctor is wise to select a hospital where there is a large turnover of interesting and complicated midwifery, and he should also seek a department where the consultants take an active interest in teaching the junior staff. Ideally, the doctor proposing a career in general practice should train as an obstetric house surgeon for six months in a large department situated in the centre of a district where the G.Ps. are conducting active obstetric practices. Only in such an area will the doctor learn to understand the G.Ps'. problems, and only in such a very busy department will there be a sufficient turnover of obstetric procedures (surgical inductions of labour, pudendal nerve blocks, forceps and breech deliveries, etc.) for the doctor to become both experienced and confident in his techniques. A further advantage is that the House Surgeon will meet many or most of the G.Ps. practising around the hospital, and this might lead to a happy introduction to a congenial practice. From this point of view, a young graduate going into general practice might choose his obstetric training post in a part of the country which suits his sporting and recreational habits—sailing, golfing, gardening, or even hunting!

Continuing Obstetric Education for the established G.P.

No longer need the principal in general practice feel he is cut-off from academic teaching after he has left the routine of hospital practice. It is now possible for him to return into residence for a two-week obstetric attachment, where a **combined academic and practical** course is provided. At St. John's Hospital, Chelsmford, a postgraduate institute of obstetrics and gynaecology has been established for the very purpose of supplying these organised courses, and it is hoped that this Institute will be given official status and financial support at some time in the near future, so that its activities may not only be continued but also expanded.

When this official backing is provided the G.Ps. of the country will gain considerably, as several other designated postgraduate institutes will then be created. These courses must be carefully planned and organised, being geared to the needs and wants of the G.P. Obstetrician. Under no circumstances should every hospital be permitted to accept an occasional doctor in residence—such a casual

and often patronising attitude to both the needs and the enthusiasm of the G.P. Obstetrician is to be deprecated. Pure lecture courses extending over several days are not the most effective methods of promoting continuing education for G.P. obstetricians. Everyone in the medical profession gets bored with lectures one after the other, and anyway obstetrics is such a predominantly practical subject it should be taught in small tutorial groups in the wards, clinics and delivery rooms. Of course, occasional lectures punctuating the in-residence course are invaluable.

Conclusions.

(1) As the G.P. Obstetricians are playing such a vital part in the obstetric services being supplied to our communities, they should be given much more encouragement. Provided each doctor is well trained and taught in a busy obstetric department before he enters general practice, and he is given the opportunity of attending an organised residential post-graduate course every few years, he is capable of a large contribution towards an improved and secure national obstetric service in this country.

(2) This now well-trained G.P. Obstetrician should be provided with the equipment and facilities to which his tuition has attuned him, for only in this way may he guarantee the safest and most efficient obstetric care for the mothers and babies in his practice. Without any doubt he should practise his obstetrics in **G.P. Maternity Units.**

CORRESPONDENCE

The Tower Block

SIR, In Mr. Burfoot's article "The New Guy's", which appeared in the Two Thousandth Edition of the *Gazette*, he reported that the next phase of development at Guy's was included in the Ministry of Health capital programme, but that in it the commencement of building was not planned before 1970 or 1971. Because of our urgent needs, the Board have pressed for an earlier start, but the country's subsequent financial difficulties have caused a delay in approval of our proposals. I am very pleased to let you know that Lord Robens has now had a letter from the Minister of Health in which he agrees that the proper course is to go ahead with building the Tower Block, starting as soon as practicable. He has yet to give formal approval which we expect will shortly follow, now that the principle is at last agreed.

At present the Minister is only able to guarantee funds for the boilerhouse and for the framework, floors and external cladding of the rest of the building. Because of this he has had to reserve the right to decide on its completion in the light of financial circumstances as they are when this stage is reached, and Lord Robens has agreed to accept this reservation.

This decision of course means that we must continue detailed planning with all speed so as to be ready to start and complete the building without delay. I know that everyone interested in Guy's will be as encouraged as I am that it has been possible to reach this favourable solution to the problem.

Yours, etc.,

A. E. ORCHARD-LISLE,
Chairman, Tower Block Building Committee

Counting House,
Guy's Hospital, London, S.E.1.

Satisfaction in General Practice and Emigration

SIR, In view of the many public strictures made on general practice in this country by young doctors in recent months, may I, as a general practitioner, make a few remarks in its defence through the courtesy of your columns?

It is true to say that one can practise as good—or as bad—medicine as one wishes in any country, including our own.

In this country one can practise normal and abnormal midwifery within the limits of one's capabilities. Minor surgery is practised by some, admittedly largely at their own expense, but this is surely a small price to pay for the retention of one's interest. With modern drugs and antibiotics it is certainly possible to treat the majority of medical conditions in the home, providing the domestic situation is satisfactory. In this area where full pathological, radiological and physiotherapy facilities are available to practitioners—backed up, if desired, by domiciliary consultant opinions—the patients, far from suffering, often benefit by domiciliary treatment.

For those who are interested, clinical assistantships in most spheres of medicine are available in many areas.

During the past nine months I have interviewed several young doctors in my search for a partner. As a single-handed practitioner I have been at a disadvantage in so far as the majority of those interviewed are mainly interested in entering either into larger practices, or in spending a trial period in practice in this country before deciding whether to emigrate.

It has seemed to me a pity that there are not more adventurous young doctors prepared to take an active part in the formation of a partnership or group practice rather than enter a large group where, as the junior, they would have little say in policy.

Of those considering emigration, I have not been convinced that the practice of good medicine was their sole objective; a recent applicant explained that, in Canada, he would be able to spend thirty-five minutes examining a patient with recurrent sore throats, and would also be able to remove patients' gall bladders. The necessity for the former made me question the capability for the latter and whether, in fact, the patient would benefit in either case.

Furthermore I have heard from various colleagues that many young doctors, even those with obstetric or other diplomas, are unprepared to accept the responsibility for even the most simple procedures, for example, artificial rupture of the membranes.

I wonder now at whose door the cause of the present dissatisfaction should be placed; whether at the door of the young practitioners, some of whom have sometimes forgotten the best interests of the patient in their avowed desire to practise good medicine, or whether at the door of those established practitioners who, by publicly bemoaning their lot, have, perhaps, dissuaded the younger men from joining them.

I trust that Guy's will continue its long tradition of producing practical men capable of rising to any situation and practising good medicine to the best of their ability at all times.

There is certainly a future in general practice and men of this calibre will always reap their reward from the satisfaction of seeing a good job well done.

Yours, etc.,

J. SCOREY

Griffin Cottage,
Woodrow,
Amersham, Bucks.

Or Advice for Emigrators

SIR, I was extremely interested to hear, on the B.B.C. News from Britain, this morning, that many, many Guy's residents were considering emigration.

I took the plunge in October last year and have not regretted it in the least.

In spite of the rather gloomy prospects as regards practice in New Zealand, put out by New Zealand House, there is still a shortage of General Practitioners in New Zealand. Also this country offers great opportunities to practise medicine reasonably, having the time to spend on patients, and not the rat race of U.K. If one sees more than fifty patients daily, the powers that be are liable to look into the matter as to whether one is doing too much!!

The ideal number of consultations is about forty. If anyone is interested I would be delighted to send what information I can.

Yours, etc.,

L. E. MILTON

New Zealand Insurance Chambers,
Childers Road,
Gisborne,
New Zealand.

South Africa Again

SIR,—Once again you have allowed to be published an uninformed nonsense amongst the letters, this time by Stafford-Clark, who, up to now (and I am in the middle of reading his latest book) I had regarded as one of the balanced psychiatrists.

As a refugee from the N.H.S. I only wish I had come out here earlier than 1957.

I can only suggest that this Consultant should follow the lead of people like Brock, Kilpatrick and Doherty and come out here and see for himself just what goes on. I assure him of a pleasant surprise.

As I see the situation in U.K. (and hear about it from two Guy's men who have recently returned to S.A.) there should be more suppression of Communism than there is.

The solitary confinement S.-C. mentions is only to the person's house, which is a very good place to keep a Communist or a fellow-traveller.

I would be only too pleased to offer hospitality to anyone sincerely interested in a fact-finding mission here.

There are appointments available in the country hospitals here.

I can assure you that this means a wide range of academic and practical experience in reasonably well-equipped hospitals, and the term "country" means from 1½ to 4 hours away from Durban.

Durban, of course, has a non-European Medical School which is as well staffed and better equipped than was Guy's when I was there.

It is an experience I would recommend to anyone in general and those in particular who have been misinformed about the conditions here socially and politically.

Yours, etc.,

Dr. D. P. Davis.

Provincial Hospital,
Greytown, Natal.

P.S.—If you think it would be valuable I would willingly write a small article about conditions, medically speaking, out here. It would certainly be surprising for most people and you would probably not print it because it would reverse ideas which people in U.K. seem to prefer to believe.

I also commend to your attention an article which has already been printed in the *Practitioner*—about October, 1962: "General Practice in Zululand".

SIR,—Dr. D. Stafford-Clark's letter in the *Gazette* of 9th July is what one might expect from one of his patients. The events in the so-called democratic countries of Africa should have opened the eyes of even the moderately intelligent. The diversion of "aid" funds into the pockets of the politicians and the great increase in the amount of malnutrition and preventable disease are the direct result of allowing a few to mislead the many.

Surely it is better that a few should be deprived of their liberty rather than that millions should suffer starvation and disease and be denied the advantages of industrialisation and modern medicine. The callous disregard by the Western politicians of the sufferings of the average inhabitant of the "free" nations makes a farce of their bombastic utterings. There are very few Africans in South Africa who would exchange their present nutritional and economic status for a vote and starvation. And it is the stated intention of the South African Government to encourage the African to a sense of civic responsibility, and when this has been achieved he will have more say in the government of his country. What is often conveniently forgotten is that South Africa* was inhabited by European settlers one hundred years before the Bantu immigrated from the north, and secondly that under tribal law there was no such thing as one man one vote.

Communism thrives on disease and starvation and it is to prevent these that a few are " quarantined."

Yours, etc.,

June Wyatt (née Hanna),
some time Nurse, York Clinic.

8, Heseldon Road,
Rondebosch, Cape Town.

*[*i.e. the Southern portion of South Africa*—Ed.]

But Surely Not Our Own XI?

SIR,—In its recent editions, the *Gazette* has published some sincere and outspoken letters on the subject of the abhorrent racial struggle in the Republic of S. Africa.

It is the attempt of this communication to bring the attention of those connected with Guy's to racial and social problems which exist very close at hand and in places where one least expects to find them.

Despite the denials by our national satirists and the ever-present cynics, I believe that the playing of sports and games within a student community ought to stimulate all that is best and most worthwhile in the field of "sportsmanship". One should expect an overwhelming team spirit and enthusiasm, a lasting comradeship extending from the sports field into other spheres of activity, and an enjoyment of lively entertainment off the field.

However, within the hospital at present the Cricket Club hierarchy seems to hold dear to itself all the prejudice, intolerance and shallow-mindedness that is more readily associated with bigoted 18th century politicians.

Instances of both racial and social insults are too numerous and noxious to itemize, but one can mention the fact that the Club's most prolific scoring batsman was in danger of not gaining a place in the First XI at the beginning of the season, a host of outrageous comments and arguments, team selection anomalies, and (most important) an awful resentment amounting sometimes to hostility pervading the activities of the First XI.

This resentment is clouding the enjoyment of the sport and the friendship which should accrue therefrom.

It is doubtful whether a letter such as this will radically alter the changing-room antagonisms within our Cricket Club, but certainly these puerile personal feuds are driving away players whom the XI can ill-afford to lose.

Yours, etc.,

PETER G. F. SWIFT,

East Wing,
Guy's Hospital,
S.E.1.

Friend With Rolled Up Sleeves

SIR, I must raise a protesting voice against the tone of the uncalled for article on page 427 of your last issue, under the nursing section, in which your correspondent claims that the wards are littered with debris by filthy, lazy medical students, adding to the lot of the poor overworked nurse.

It is a great pity that in matters of this nature, the laws of common courtesy are forgotten, and we descend to the level of common abuse. There is a lot that is very badly wrong with the professional relationship between the nursing staff and the medical students in this hospital, and it is understandable that from time to time one or other side may get exasperated. However, to display such lack of self-control as to put an article of this nature into print is unforgivable. It is just this failure on the part of the nursing staff, overworked or otherwise (and it is as well to remember that this hospital has almost as many nurses per patient as many have per 80-bed ward) to display common courtesy and consideration to the medical student, which causes the latter to lose patience, and want to get off the wards as quickly as possible.

Of course there is room for improvement, but the "peaceful and congenial atmosphere" the writer dreams of will not come out of articles of this nature. If it is mud-slinging the writer wants—fine. My jacket is off and my sleeves rolled up—and, oh dear, we've enough ammunition to plaster every window in the place.

But please, please, can we realize, once and for all, that this will solve no problem, but will only serve to make them worse. Please, let's do it the other way. Let's sit down and talk, politely and quietly, and see how both sides may be reconciled.

Yours, etc.,

J. P. H. JAGO

East Wing,
Guy's Hospital,
S.E.1.

Political Duty

SIR, May I congratulate you on your last issue featuring as it did one of the liveliest correspondence columns the *Gazette* has seen for many years. As was to be expected, however, one had the usual anguished plea to the effect that politics should be kept out of medicine.

In a year which sees the Health Service sinking to its knees and America, of all places, becoming the new mecca of medicine, it is pertinent to ask whether or not the medical profession is too political for its own good. For years the shortcomings of the Health Service have been common knowledge. For years the conditions of service, poor salaries, pressure of work and inadequate facilities have been patently obvious to all concerned. Apparently though, we have only just woken up to these facts in any concerted or viable fashion.

It is no use sheltering under the cloak of devotion to duty and allowing things to deteriorate as they have done in the past. A little less naivity and more political acumen would be conducive to the best interests of both doctors and patients alike.

Keep party politics out of medicine if you will but let us at least learn how to look after our own interests a little better than we have done in the past.

Yours, etc.,

PETER W. BRIGGS

Guy's Hospital Medical School,
London, S.E.1.

NOTICE

Guy's Hospital Biennial Dinner

To be held at the Connaught Rooms, Great Queen Street, Kingsway, London, W.C.2, on Friday, 7th October, 1966, at 7.0 p.m. for 7.30 p.m. The Chairman will be Sir Rowan Boland, C.B.E., M.D., F.R.C.P. The Biennial Dinner affords the most popular opportunity for old Guy's men and women—medicals and dentals—to meet together and renew the friendships of their student days.

The Hon. Secretary will be grateful if Guy's men and women who intend to be present will apply for tickets (£2 2s. 0d., made payable to Guy's Hospital Biennial Dinner) as soon as possible to the Hon. Secretary, Biennial Dinner, Guy's Hospital, S.E.1. (Tel: HOP 7600, Ext. 341, 342).

Old Guy's men and women who are proposing to attend this year's Biennial Dinner are informed that there will be a Demonstration by the Department of Medicine on Friday afternoon, 7th October, at 2.15 p.m. in the Physiological Theatre, Medical School, including clinical cases, topics of research and a talk on the Woolwich/Erith project.

On Saturday morning, 8th October, at 10.0 a.m. in the Clinical Theatre, Second Floor, New Guy's House, there will be a Combined Round in which various surgeons will give short papers.

Please notify Mr. Goodliffe if you wish to attend either session.

REVIEWS

ANAESTHETICS FOR MEDICAL STUDENTS.

Ostlere and Bryce-Smith, 6th edition, 1966. J. & A. Churchill. 132 pp. *Price* 14*s*.

This is surely one of the most student-orientated of textbooks. It provides a comprehensive and well-written account of Anaesthetics—*written for Medical students*—in an essentially practical and colloquial style.* Instead of a leisured discussion of the Physiological Sequelae of Apnoea, we have: "What to do if the patient stops breathing."

It is written so that it can be read with pleasure; its handling of the subject-matter striking an agreeable balance between the turgid and the telegraphic.

The new edition of this popular work has been revised and brought up to date without much increase in size. New sections have been added on tracheostomy, cerebral oedema, transfusion reactions, post-operative pain, and neonatal resuscitation. It is printed and bound in a most convenient format and the price is very reasonable. This book is certainly to be recommended, for it has no competitors in price, practicality, or achievement of purpose.

M. A. SIMPSON.

*(The authors recognise the student's lack of time and preoccupation with other things).

LECTURE NOTES ON PHARMACOLOGY,

by J. H. Burn. 8th Ed. Blackwell Scientific Publications, Oxford. *Price* 12s. 6d.

This book is one of a long series, intended as a guide to the subject in question, provided that larger textbooks are available for further reference. It does not purport to give all the information available on each drug discussed, and a cursory glance at the text makes this fact very obvious. Assuming that this book is intended for use at 2nd M.B., the drugs dealt with are not entirely relevant to those studied at this hospital. Emphasis is laid upon drugs which are not considered important, whilst important drugs, from the 2nd M.B. point of view are dismissed in a few words.

For a simple textbook, this one tends to be far too specific in many cases, giving the action of individual drugs which belong to a larger group. An appreciation of the general action of this group would, in the long run, not only assist the comprehension of the specific drug but also reduce the amount of reading necessary to clarify any point concerning group actions.

Many pharmacologists doubt the accuracy of this book, but I found that, although it does not agree with some of the major textbooks on minor topics, not all the major books agree with one another.

This book has been extensively revised since the seventh edition, and I would have thought that the page cross-references would also have been revised. It is very aggravating to have to scan through pages either side of that quoted, in order to find the passage to which the reference was made.

One compliment must be paid and that is to the excellent though elementary chapter on statistics found at the end of this edition. It explains in simple terms the reasoning behind concepts such as "significance", "error" and "deviation". For any detailed understanding, however, larger textbooks must be consulted.

On the whole, I found this book not only rather difficult to read, but also extremely tedious to revise from, in view of its lack of useful information, requiring constant reference to other larger textbooks. I used this edition while studying for 2nd M.B. and I would not advise any student to follow my example.

J. O. Soul.

" PERIODONTICS FOR THE DENTAL PRACTITIONER."

J. D. Manson, M.Ch.D., F.D.S.R.C.S. Henry Kimpton. *Price* 65*s*.

It has been said that few authors actually expect their prefaces to be read, and most are written on this assumption. The preface to this book is admirable, and the author both clearly states his aims and disposes of the professional torpor too often found when dealing with periodontal diseases.

The text is admirable with very little superfluity, basic principles are clearly laid out and their relevance to treatment stressed. Since this is primarily a book for practitioners, it is refeshing to see that emphasis is laid on periodontal disease as a part of total dental health. The part played in the aetiology by dentures, inlays and other restorations is admirably dealt with and will repay careful study on the part of any reader. It is also welcome to see accent placed upon the dynamic aspects of the dentition, and the chapters on occlusal trauma and rehabilitation are eminently practical.

The line drawings are really excellent, and it is a pity that the chapter on instruments copied the archaic illustrations from a dental supplies catalogue.

In short, a book which fills a very real need and one which dental students also should read to appreciate that the treatment of our most ubiquitous disease is both logical and practicable.

J. M. A. Wilton.

GLANCING BACK

by

A. Falwasser M.B.E.

My six weeks in the Preliminary Training School, for which I had paid my fee of £6, was behind me, and at the beginning of April, 1926, I entered my first ward.

I fail to remember what I had expected to find, but certainly my imagination had never conjured up anything in the least like the picture which met my eye. I still see it most vividly. A roaring coal fire in a huge open grate surrounded by women, girls and infants of all shapes and sizes, with hair in curlers, plaits, or top knots; some glamorous, some definitely not; but all apparently joining in a spicy bit of gossip. Dominating the whole scene was a fat, jolly-looking woman, head bristling with curlers, completely toothless, clad in a too-tight red serge dressing-gown trimmed with black braid. On her lap, gurgling happily, was a tiny baby with a ghastly hare lip (but what gorgeous eyes!) and she was feeding him from a mug with a spoon. Should I ever learn to catch the bubbling overflow so skilfully, thought I? Later I learned that this was Mrs. 6, a veteran patient, and if in doubt as to any ward procedure she could always put me right. It was she who told me the right way to make tea when I was desperately searching for a teapot. "Easy ducks," said she, "yer puts the tea in that there big strainer and runs the water through it into a jug—and we likes plenty o' milk in the bottom first." I think the teapot was introduced into the wards a year or so later, as also were cups and saucers instead of mugs. Trays were a much later refinement except for the so-called "tray patient", and to qualify for this privilege one had to be a member of the medical or nursing staff.

Opposite the fireplace was Cot B, and lying there propped up by pillows in a most unnatural position, an immobile baby with wide open eyes and a wax coloured face, scarcely breathing and—oh horrors! —a large rubber tube was coming from inside the bedclothes and dangling into a bottle containing something yellow and slimy looking. Never did I summon up enough courage to touch this fragile object, although I was instructed to "mount" her four-hourly. I got as far as putting a screen round, and wondered if her nurse knew why she always found her baby wet, and if I should ever overcome my cowardice. There was a Mrs. 10 who groaned, and together with several other patients had a couple of cords tied to the bed rail, which

also disappeared into the bed in a mysterious way, but I soon learnt about "donkeys" and Fowler's position. There was Cissie, a Jewish girl, who screamed; and Elsie, who whined; but in spite of all this, the general atmosphere was one of cheer and good fellowship, with the patients in league to protect me from my superiors. I was terrified of almost everyone, and my foolishness and ignorance seem quite unbelievable now.

"Report", given by the Head Nurse, who obviously regarded me as the lowest of God's creatures, had no meaning at all as far as I was concerned. The recurring topic was always oil. Not for a long time did I discover that castor oil given pre-operatively meant starve the patient, and oil given post-operatively meant that the poor thing might at last take a little sustenance. Never could I fathom which patients were allowed to eat, or where they disappeared to from time to time. On one occasion I clearly remember hearing "Mrs. 7" "went" at 8 o'clock. Screens were round No. 7 at 9 a.m., coffee time, but determined not to repeat a previous error of missing out a patient completely because she was being bathed, I walked in boldly with the coffee, and saw, for the first time, the performance of last offices! Somewhat shaken, I beat a hasty retreat.

Apart from the frequently-recurring meal times and the agony of trying to remember who was allowed what, my main function was cleaning. I swept half the ward three times daily, and can still see my black woollen stockings getting greyer and greyer as the dust swirled around me, and there was brass to clean—bed knobs, rims round tables, medicine trays, plant pots (the aspidistra leaves had to be polished too, but with a drop of oil, not "Brasso"), and the carrying lamps used by the night nurses. These also had to have their wicks trimmed and be filled with paraffin. There were innumerable macintoshes to scrub and nappies unending to wash, but worst of all was the job of counting and sorting soiled linen on alternate mornings—piles and piles of it—and even the thought of the stench can still make me feel sick.

It didn't take me long to learn that a ward maid could be either a useful ally or a fiend incarnate. Considering their long hours and hard work the latter state was not surprising. The junior maid spent almost all day scrubbing—the ward floor (with sand to whiten the boards) all the morning, and the stone floored sanitary block in the afternoon, varied twice a week by polishing the central linoleum strip and its brass edging on Wednesday and Saturday. All on hands and knees. She also filled the coal buckets from the balcony bunker, and stoked the ever-roaring fire, having cleaned and blackleaded the grate in the early morning, and attended to the cooking stove which was situated beyond the angle of the ward. This was used for cooking the patients' dinner. The senior ward maid, a vastly superior female, who acted as Sister's personal maid, "doing" her rooms and often looking after her like an old-fashioned Nanny as well, was also the ward cook, and good plain cooks many of them were. But the diet was utterly unvaried, and by present-day standards (excepting the mid-day meal) very meagre. There was porridge, bread and margarine for breakfast at about 5.30 a.m. (officially 6 a.m.) and the night nurses would add anything the patient cared to provide (only diabetic and

gastric patients fared better), coffee was at 9 a.m. The mid-day meal consisted of roast beef, greens and potatoes on Monday, Wednesday and Friday; roast mutton, greens and potatoes on Tuesday; boiled mutton, boiled carrots and onions and potatoes on Thursday; and cold boiled beef, potatoes and salad on Sunday. Always rice pudding and occasionally stewed apple to go with it. Most wards provided boiled chicken about twice weekly and steamed fish daily, and always an egg custard—the same from week to week, never a variation. With the exception of the meat and rice pudding, which had to be fetched from the central kitchen in large cans, everything was cooked in the ward on the old-fashioned kitchen range. Whether the smell of boiling cabbage improved the appetites I do not know, but the bubbling pots on the stove certainly produced a homely atmosphere. Tea at 3.30 p.m. was accompanied by bread and margarine. Butter was never provided, and sugar never lasted beyond breakfast time, so almost all patients kept supplies of butter and sugar in their lockers, together with a great deal of other supplementary food—some of it most unsavoury and messy. Cocoa and bread only was provided for supper at 6 p.m., but an enterprising nurse might save any left-overs from dinner and fry up a "bubble-and-squeak" for the hungry, if there was time.

My second ward was totally different from my first and I fell on my feet immediately, mainly because I had a Head Nurse who took me under her wing, mothered me a little, tought me a lot in a most unorthodox fashion, encouraged and sometimes praised me. It was here that I learned the use of "balcony comforts", those beautifully-knitted caps, scarves and mittens, in colours ranging from heather mixtures to rainbow effects, provided by the Ladies' Association, and worn by the patients who braved the elements on the open balcony, regardless of the weather, for the sake of a pipe or cigarette. No smoking was ever allowed in the ward. I also learnt about sputum pots, those gruesome objects with funnel-shaped tops through which no patient could ever aim straight.

My pride knew no bounds when called upon to help wring out the blankets for hot, wet, packs, exhausting though it was; and I remember my feeling of importance as I stirred the citrate into an open flask of blood as it dripped from the donor, and later held the funnel through which it ran to the patient (how my arm ached!) while the Houseman held the needle in the patient's arm, and Sister treated the inevitable rigor with hot bottles and blankets. True, I still had my agonizing periods, as when I made beds with Sister each morning, never quite able to keep up with her amazing speed, and always finding her waiting at the next bed when I was still staggering under the burden of waste-paper baskets containing the clean and dirty linen and the bed brush, which had to be transported from bed to bed. Sister was marvellous, but a race apart, so aloof and superior did she seem. The day I made a spontaneous remark to her was a grave mistake. It was on the day of the nurse's "change", and I left the ward in great sorrow, so happy had I been there, and in great apprehension as to where I might have to go next. But when I faced Matron in the office I could hardly contain myself for joy when she sent me back to the same ward. In great

exuberance I burst through the ward door, almost into the arms of Sister—"Sister, I've come back!" said I. "Yes, and you'll find a lot of dirt behind the bathroom door!" was the sharp retort.

It was my first night duty which made me feel a real nurse. Mine was the "septic ward", divided into male and female, and including Mothers with puerperal fever, and their babies, and sick children in their cots as well. Needless to say, it could be hectic. And with the Head Nurse often tied up in the theatre during the early part of the night, I felt it was I who ran the ward. There were times when the four-hourly hot boracic fomentations (H.B.F's for short) could number as many as fifteen, and alone I did them, almost taking the skin off my fingers on the coarse holland wringers. But there were always the long, quiet spells during the small hours of the morning, when I made dressing pads and gauze sponges by the thousand, in the light of my little shaded, oil lamp, with Southwark Cathedral clock reminding me of each passing hour. The morning rush, when it started about 4 a.m., jolted one back into swift action and was like a planned battle. How we got through the bedpans with the aftermath of castor oil, dressings, fomentations, babies' changing, babies' feeding, rectal infusions, enemas, temperatures, medicines, breakfasts, and even a few back treatments and some bedmaking I cannot think. Somehow we did, and the achievement of so much brought a wonderful feeling of triumph.

Two nights off per month for a night nurse and one day off per month on day duty seemed ample reward for my labours, in spite of the fact that one might have to go longer than that period should one change wards at an unpropitious moment, and come back for a lecture or class should it fall in off-duty time. I am ashamed to say that I remember very little about lectures except the ghastly rush to finish one's work before going at 8 p.m., and one's unpopularity with the rest of the ward staff for leaving them shorthanded, in spite of the fact that the hour had to be made up at some other time. But the "dispensary" lectures do remain with me—not for what I learnt, but for our atrocious behaviour. We might have been fourth-form schoolboys, for we ragged poor "Lord Lysol", then chief dispenser, to distraction, and made up the strangest concoctions from our prescriptions.

Having been brought up in a rather Victorian atmosphere at home, and coming from a strict boarding-school, the restrictions in the Nurses' Home did not irk me as they did some of my fellows, though the rule that a hat must be worn if attending a meal in mufti did seem, even to me, unnecessary. Meals were compulsory—not that I ever needed compulsion—I was constantly hungry, in spite of stuffing in as much bread as time allowed, and anything else that came my way, including crusts of bread when preparing patients' teas. Our food was not scanty, but I had a voracious appetite. Bedrooms were little, cold, clean cells—no flowers and only five articles laid out—and, yet oddly enough, the big sitting-room downstairs was almost always empty. We had our fun, crowded into each others' bedrooms—taking a blanket or hot water bottle with us for comfort—or we had a two-penny ride on top of a bus to get a "blow" and rest our feet; and

buttered crumpets, so delightfully filling, at Lyons Corner House if funds permitted. Our quarterly salary of under £5, received from Matron's own hand as she studied our neatness and deportment, did not allow for expensive tastes.

I could reminisce indefinitely about the whole of my training and the many years that I have spent at Guy's, but again it is a picture of some small incident that comes into my mind's eye—my Mrs. 6 in her big wicker chair beside the ward fire; Margaret, the notoriously formidable ward maid, with skirts swirling, slamming down a dish of fried fish; a wizened old Grandpa, clad in bright, woolly cap, and muffler, heading for the balcony, with pipe at the ready; and a fat old granny, her many chins a-wobble with fervour, introducing me, to my extreme embarrassment, to a visiting cleric as her nurse "who prays most lovely". There is the air-raid casualty, tears streaming down his face, repeating over and over again, "Them two beautiful birds"—he had lost his entire family, not only his canaries; and the nervous old lady, wide-eyed and alert in an otherwise somnolent ward after a brief air-raid, refusing her chloral with "No, no, my dear, I'd rather die conscious". I can visualise the mother of a badly injured child, standing beside the bed, head swaying from side to side, saying, "Lor' love him, Lor' love him", and the tiny little hands of six-year-old Bob, from Lincolnshire, busily packing the contents of his Christmas stocking to send home for the family, demanding "the lend of a piece of string".

I have had many titles in my day, from the orthodox Nurse and Sister through the full range of endearments such as Dear, Love and Darling, to Duck, Sis, Gal, Mate, Ma, and even "me old cock". On reflection, I think I like Ma best.

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NURSING SECTION

Why not Nursing Certificate Courses at Guy's ?

The emphasis on Nurse Training is now equally divided between student education and post graduate teaching. More hospitals are finding that one of the only incentives to keep trained nurses is to provide them either with certificate courses or to give them in-service training, to keep their interests and encourage them to go on further.

A number of large teaching hospitals are offering courses to nurses wishing to gain more than the experience offered in State Registration.

Courses are run in many hospitals now for the B.T.A. certificate, Eye diplomas and Orthopaedic certificates—to mention only a few. For shorter courses, certificates are awarded in Intensive Care nursing, Cardiac Surgery nursing and Theatre nursing.

An excellent Teaching Hospital such as Guy's has everything in the way of revolutionary and advanced techniques in Surgery and Special subjects. The Intensive Care unit can offer all that is necessary for a short six month certificate course or in-service training. Indeed, Guy's cardiac and thoracic nursing can give experience which is second to none. And not only does our chest surgery offer the best experience, genito-urinary surgery and advanced abdominal surgery techniques can give nurses all they require for a "Special" subject course. Theatre course certificates could also be made available.

Inevitably it will be necessary to devote time and money to set any course off onto the right footing. Tutors will need to be found and practical and theoretical aspects carefully planned.

To make available to non-trainees its full resources, a hospital should offer them as practical material for the education of those State Registered nurses who were less fortunate in their training experience.

STAFF CHANGES AND APPOINTMENTS

DEPARTURES

Sister H. Broadbent, S.R.N., R.S.C.N., from Evelina Hospital Night Duty.
Sister P. MacMillan, S.R.N., R.M.N., from the School of Nursing.
S/N S. Evans, from Ruth Night Duty.
S/N H. Frohlich, from Nuffield A
S/N S. Giles, from Out-Patient Department.
S/N S. M. Harrison, from the Out-Patient Department.
S/N J. Letchford, from Main Theatres.
S/N J. Macgregor, from Barnabas Theatre.
S/N E. Mayer, from Cornelius.
S/N E. J. Samuel from Cornelius.
S/M G. Walsh, from Nuffield D.
S/N S. Winslett, from Main Theatres .

NEW APPOINTMENTS

Mr. P. Unsworth, S.R.N., R.M.N., R.N.T., Tutor. Trained at Lewisham General, Bethlem Royal and The Maudsley Hospital, to the School of Nursing.
S/M A. Awuah, to Victoria Ward.
S/N M. C. Davidson, to Lydia Ward.
S/N E. Herbstreit, to Patience Ward.

CHANGES

Sister A. L. Amsden, S.R.N., O.N.C., C.M.B. Part I, to Assistant Matron in Matron's Office.

SPORT

BOAT CLUB

Twickenham Regatta, 28th May

To this regatta we took an eight which was composed of members of the first, second and third eights of the previous month. We had several evening outings in training, and on the Thursday towed our new shell up to Twickenham.

Unfortunately, despite strict instructions, some of the crew were very late in arriving on the Saturday and we were forced to row quickly down river to the start and turn almost immediately. There was a bitter wind which further numbed our keenness. Molesey junior eight were our opponents and went right ahead on the start. For our "tens" we took Guy's "twenties" but to no avail. We held them until half-way up the course when they increased their rate and left us standing.

The race was disappointing as it showed up a lack of basic co-ordination in the crew. The remainder of the day was spent profitably in the enclosure watching some exciting racing. A promise of Twickenham coaching was secured for next year's crews.

Horseferry Regatta, June 2nd

Horseferry Regatta is a small regatta held near our own boathouse on the same day as Walton Regatta.

The identical eight with previous little extra training was entered for the junior eights. It must be remembered that this eight was entirely novice with only one or two experienced oarsmen in the boat. At last our coxless four was persuaded to appear on the river and actually to take part in a regatta. They were fortunate in being able to borrow a boat to replace their own which had suffered at the hands of an errant sculler. The four rowed first against Quintin B.C. and were well beaten by a class crew. They were unlucky in having to replace an unwilling member by a good but untrained oarsman.

The eight was drawn against the home club's only eight. We started right on time and went up very smartly due to an excellent lead by stroke and seven. We managed to sit on Horseferry past the U.L. Boathouse and drew away before the iron bridge. However, on passing the City Barge, Horseferry drew level very fast indeed amid a confusion in our boat. They were lucky to have had good water along the island because as soon as they hit the swell they dropped back and the race was won. This considerably elated our spirits—a win over the host club!

Bedford School were our next opponents, a crack second VIII who were currently beating their own first VIII. The tide had changed so that we rowed in the opposite direction, from Brentford Lock to Horseferry. We were optimistic of our chances because the water was far rougher than Bedford's Ouse. We had another good start, and under-rating them, we went half-a-length ahead. During this time they noticed that the Brentford wall was closing on them and their cox steered into one of our blades. Amid many and varied cries their cox raised an inky paw and appealed. The umpire then vanished as if disqualifying us. Our gallant spirit forced us to row on against these young lads who have probably never seen a pint of beer in their lives. They pulled steadily past and won by a few yards. We discovered to our delight that we had not been disqualified and that we were described as a crew of great experience in their school magazine. So be it!

Crews

VIII

Bow P. Sharpe
2 P. Moulder
3 N. Daws
4 J. K. Skuse
5 M. C. Mace
6 P. Hunt
7 P. J. Burton
Stroke R. Mandeville
Cox T. Kirk

IV

Bow G. Stygall
2 M. Preece
3 J. Pook
Stroke R. Forrest

M. C. MACE

Pangbourne Regatta, June 25th

At Pangbourne, the Guy's crew, by now reduced to a notorious, if not notable, four, were drawn in the first round of the novice IV's against a top school crew.

After a few warming up exercises to dampen the spirits of the opposing crew, the race was started by a founder member of the A.R.A.

From the start it was obvious that glorious things were to be done, aspirations that slumped ten strokes later as the school acquired a half-a-length lead.

Guy's, however, came back level by the half-way mark, as the school steered under duress for the bank, and held this position for all but the final half-minute when the vices of the preceding night caught up with our crew (notably stroke) and the school drew away to win by a distance quoted variously as two lengths and . . . two lengths.

Crew

Cox T. Kirk
Stroke R. Mandeville
Bow P. Sharpe

Huntingdon Regatta, July 2nd

The climax of the summer rowing came at Huntingdon where the novice four was again entered.

The racing was carried out in true G.H.B.C. style. Five good men and true, entirely unrehearsed, assembled on the bank from the four corners of the Huntingdon hostelries, and prepared to do battle.

The first race, against Evesham, was carried out with great vigour and determination. The result? An unexpected win for Guy's and the prospect of glories to come.

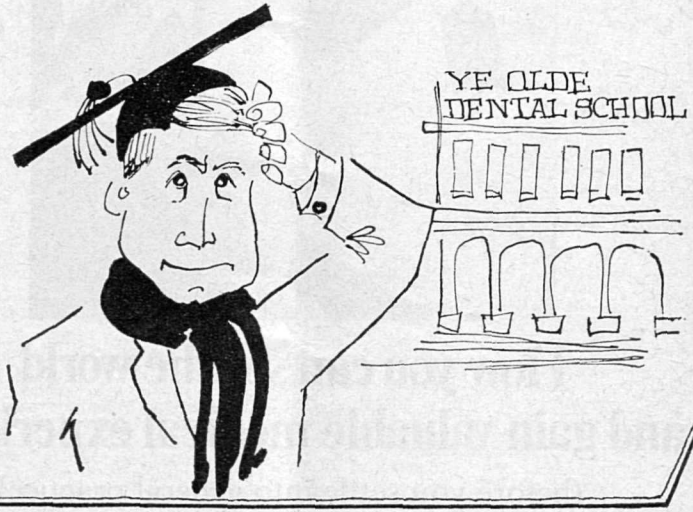
The next race, against Newark R.C., was attacked with the same enthusiasm but, alas, success was not to be ours. The opponents' half-length victory has been attributed to dishonest coxing, poor choice of rating, and even the pill. However, the succeeding drowning of sorrows was greatly enjoyed and served to encourage us for races to come.

Crew

Cox T. Kirk
Stroke R. Mandeville
3 J. Pook
2 P. Hunt
1 P. Sharpe

J. K. SKUSE

AFTER GRADUATION... WHAT?



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HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Clinical Pathology,** vacant on 1st October, 1966, with appointment for one year in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be lodged with him not later than **12th September, 1966.**

GUY'S HOSPITAL MEDICAL SCHOOL

A Registered Medical Practitioner is required to help with a Study of the Medical-Social Aspects of Community Care being undertaken by the Social Medicine Unit. The appointment will be for one year in the first instance, starting as soon as possible, and the salary will be within the range of £1,200—£2,200 p.a. depending on experience. Further particulars may be obtained from Dr. J. A. D. Anderson, Department of Medicine, Guy's Hospital Medical School, London, S.E.1.

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited from Medical Social Workers for **a research post in the Social Medicine Unit** to help with a Study of the Medical-Social Aspects of Community Care. Experience outside hospital is essential. The appointment will be for one year, starting as soon as possible, and the salary will be according to experience. Further particulars may be obtained from Dr. J. A. D. Anderson, Department of Medicine, Guy's Hospital Medical School, London, S.E.1.

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for **two research posts** to assist with a Study of the Medical-Social Aspects of Community Care being conducted by the Social Medicine Unit.

(a) Senior Appointment (Salary £1,250—£1,800 per annum): Sociologist with Research Experience.

(b) Junior Appointment (Salary £787—£1,050 per annum): Experience not necessary. Could be recent graduate.

The appointments will be for one year in the first instance, starting as soon as possible. Further particulars may be obtained from Dr. J. A. D. Anderson, Department of Medicine, Guy's Hospital Medical School, London, S.E.1.

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D. P. Jacobs
D. B. Kennedy
R. S. Loomes
Jean A. D. McLean
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R. M. H. Phillips
R. C. N. Pinckney
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June, 1966

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FROST.—Dr. P. J. Frost, "Mogador", Lodge Avenue, Church Street, Wollingdon, Eastbourne, Sussex.

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LANE.—Dr. J. L. Lane, M.Med.Otol., University of Cape Town, South Africa.

WARNER.—Mr. and Mrs. F. S. Warner, 15, Melcombe Regis Court, 59, Weymouth Street, W.1.

KIRKPATRICK.—Dr. W. R. Kirkpatrick, 25, Ballagale Avenue, Surby, Isle of Man.

BIRTHS

HAYMAN.—On 10th August, to Gloria (née Clarkson) M.C.S.P., and Robin Hayman, L.D.S., R.C.S.(Eng.), of Odstock, Salisbury, a son, Jonathan, a brother for Deborah and Rupert.

MURRAY.—On 9th July, to Mary and John F. Murray, B.M., B.S., of 23, Sydenham Rise, Forest Hill, S.E.23, a son, John Marcus, a brother for Grainne and Julia.

NEALE.—On 15th May, to Lois and John Neale, B.D.S., of 64, Kingston Crescent, Portsmouth, Hants, a daughter, Fiona, a sister for Heather and Claire.

PENNEY.—On 20th August, to Belinda (née Rudd) and Dr. St. John Penney, of Bishop's Castle, Shropshire, a son, a brother for Adrian, Oliver and Charles.

WABOSO.—On 25th July, 1966, at Borromeo Hospital, Onitsha, Nigeria, to Margaret, wife of Marcus F. Waboso, M.R.C.O.G., a daughter, Nnena, sister for Paul Uche, David Gogo, Andrew Chima, and Martin Okoroma.

MARRIAGES

BELL—MURRAY.—On 6th August, at Fleet, Hampshire, Lt. Duncan R. F. Bell, B.A., R.N., to Elizabeth Ann Murray, S.R.N.

PAGLIERO—SAUNDERS.—On 9th July, at St. Nicholas Church, Looe, Cornwall, K. M. Pagliero (Paggers) to M. A. Saunders (Annie).

DEATHS

BELL.—Suddenly, on 19th August, Alan William Adrian Bell (2nd B.D.S. Student).

LAW.—Brendan Law, L.D.S., R.C.S., of 67, Greyhound Lane, Streatham, S.W.16.

PERCY.—On 20th June, at The Little Glebe, Creech St. Michael, Taunton, Arthur John Percy, L.D.S., R.C.S.(Eng.).

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

EDITORS M. F. D'SOUZA and D. S. ROBINS
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FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2038

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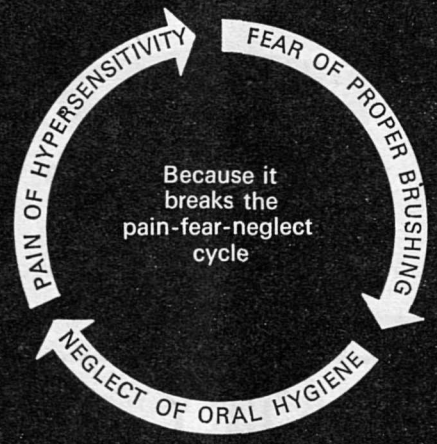
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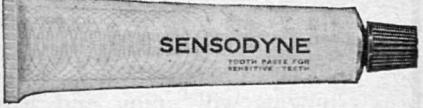
1. Cohen, A.: Oral Surg., Oral Med., Oral Path. 14:1046–52 (Sept.) 1961. 2. Skurnik, N.: J. Periodont. 34:183–185 (March) 1963. 3. Zelman, H. and Hillyer, C. E.: New York J. Dent 33:259–262 (Aug-Sept.) 1963. 4. Ross, M.: J. Periodont. 32:49–53 (Jan.) 1961.



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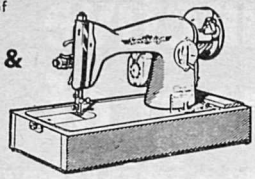

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PASSIM

Advertiser's Announcement

All praise must go to the Matron's office for their handling of the extremely difficult situation posed by the current shortage of trained staff. In the face of a world shortage of qualified nurses, for Guy's to have managed for so long without curbing its activities, has been largely thanks to the efficiency of this office and the recent brief closure of Queen, Patience and Caleb wards, coupled with the previous two-bed cut-down on the surgical wards and the more careful use of Theatre time is but small restriction when one considers what could have happened. Brief closures of wards may again be necessary in the near future and the two-bed cut-down and the ban on extra beds (moves which we are assured are very effective), will need to be continued for a while if standards are to be maintained. But the end is in sight. On page 472 we are reprinting an article from the *Nursing Times* that puts the problems more fully.

Throughout the country, however, the nursing situation is critical and in some instances the Ministry is directly to blame. The money to pay nurses has been frozen and Matrons, already with such a desperate shortage of nurses that they have been compelled to close wards, have actually had to turn away applicants for the jobs they so badly need filled. Guy's plight is not as bad as this but it is the duty of the bigger hospitals to draw the attention of the country to the seriousness of this crisis.

Local administrative and social conditions must also be held partially responsible for some of the underlying difficulties of keeping staff. Unlike so many other hospitals, however, we are assured that Guy's is very fortunate in its nursing administration. Whereas elsewhere trained nurses complain bitterly that they are not given sufficient respect, have difficulties making holiday arrangements, have their wishes thwarted as to the wards they prefer to work on and are dissatisfied with their nursing health services, here at Guy's, because they have direct access to the Matron, most of these complaints are never heard.

Socially, too, Guy's has a fortunate reputation that is an abiding attraction (and recently there has been talk of reviving the former custom of having monthly parties with the students). All in all, the main causes here seem to stem from the difficulties of changing over from the older system to the more modern shift system and as such

should only be short-lived, leaving behind an improved situation for all. Already there is an efficient deployment of existing nursing manpower and no ward is over-staffed while another is under-staffed, which is a tribute to the organization.

As far as Guy's trained nurses returning to work in the hospital is concerned, it is still true that Matron's office requires references, but the fact that they have worked here quite naturally speaks well for them and indeed it is to be hoped that they will come back. Finally, we could scotch the rumour that nurses already working in the hospital are being asked to return; this only occurred to a few senior nurses and was perhaps the only administrative error that has been made throughout the hospital's long history. The record of Matron's office has, in fact, been a completely clean (although slightly pink) sheet.

Grass Roots

So true in general, so fallacious in particular.

Gibbon.

A great hospital, like any institution, builds about it and comes to consist of a specialized micro-milieu. Those who compose it enjoy referred pride in their association and in return the hospital boasts of its individual successes. Guy's society is our closest example.

The society here consists of many different sections, each having its place. The relative importance of each often enters the realm of pure philosophy. A recent article in the *Gazette* remarks that this has been known as a surgeon's hospital, but if the view is still widely held it serves nothing apart from surgeons' egos and feels the fallacious glamourized layman's view of medical care in which the operating theatre is the holiest of holies. That it is a teaching hospital is still in places a creed to which mere lip service is given, whether the field is the study of nursing physiotherapy, radiography, dentistry or medicine.

Such a large society is prey to the apparently inevitable malignant change that accompanies rapid growth. Thus the inhuman administrative machine reaches the critical Frankenstein stage just when it is needed most to protect rather than harm the individuals subject to it. Those who push the buttons through no fault of their own often move into the position wherein they are unable to become aware of the individual components. As a result, when the machinery fails to produce the required product, symptoms become the prime concern rather than the pathology. Thus we sincerely trust that the nursing enquiry will not forget the necessity of interviewing both training and newly-qualified nurses in confidential surroundings so that the admirable symptomatic treatment elaborated on page 474 can be made really effective by dealing concurrently with the cause.

The problems of under-staffing are by no means unique to Guy's. As a leading hospital it can, however, show how attention paid to the opinions and ideas of all levels of its society can act prophylactically

for the future. Attention can be better given to measures which will bring various sections closer together so that their "Guy's pride" is not referrable to their own section but to the institution as a whole. Intelligence there is plenty of, and we hope to see its heyday here and now when so many other hospitals are floundering. We have given some lead already, in the local definition of that very word intelligence—"the capacity to interpret experience, to learn from it and to modify behaviour in the light of it".

We would like to draw our readers' attention to the clinical lecture mentioned below in Guy's Diary, on "Diseases of the Pharoahs". This is being given by Professor Paul Ghalioungui, who is the world expert on this subject and it should prove to be most interesting.

Obiter Dicta

Senior Administrative sister to forlorn third-year nurse complaining at being given a further three months' night duty after having already done six months this year: " Isn't that a pity."

GUY'S DIARY

SEPTEMBER

29th Th. 1.00 Professor GHALIOUNGUI, F.R.C.P.
Clinical Lecture. "Diseases of the Pharoahs".

There will be a series of films entitled "BRAIN AND BEHAVIOUR", to be shown in the Anatomy Theatre on Tuesday at 5 p.m., commencing on Tuesday, October 11th.

The programme is as follows:—

OCTOBER

11th Tu. 5.00 "Us and Them. The Physical Framework".

18th Tu. 5.00 "Instinct and Reaction. Reason over Reflex".

25th Tu. 5.00 "The Emerging Pattern. The Adult under Stress".

NOVEMBER

1st Tu. 5.00 "The Adult under Treatment. Them and Us".

RESEARCH IN GENERAL PRACTICE

by

G. I. WATSON, M.D., M.C.G.P., D.T.M. & H.

Once or twice in a lifetime a person may be admitted to hospital for special nursing, investigation or specialist treatment, to give birth or to die. Nearly everyone else, when ill, stays at home under the care of his or her doctor until recovery or death. The mere quantity of ill-health known to general practitioners is at once both a challenge and an obstacle to research. There's no lack of subjects needing to be studied, nor of problems to be solved, most of which are never seen nor taught about in hospital.

"Can anything be done for me?" is the burning question for every patient, whether at home or in hospital. He goes to the doctor for treatment. Therapeutic research may well have begun as a by-product of the kitchen. Food gatherers in any country, modern or archaeological, are liable sometimes to eat things which disagree with them—or worse. In this way over the years local knowledge about the side effects of various berries, leaves, stems or roots, which looked edible, would be painfully acquired. The "experiment" may have been repeated, sometimes intentionally, and gradually a body of secret knowledge about poisons and other drugs would be collected. For example, the value of foxglove for dropsy was passed on to Dr. William Withering by an old Shropshire woman. Through his studies and experiments in general practice, digitalis was eventually added to the Edinburgh Pharmacopeia in 1783. In more recent times rumour has it that an Irish "witch" had been using blue mould to heal wounds long before a spore of *Penicillium notatum* landed on that famous petri dish. How many more such pieces of local knowledge or inspired observation remain to be tapped? Probably few here but abroad no doubt there are many. My first therapeutic experiment arose from the remark of a young woman that the only time her hands had ever been free of chilblains was when they were stung by nettles. I imitated the process, first by using minute injection of histamine and then with Bee Sting ointment (Watson, 1941). Her chilblains were cleared with both treatments.

In the jungle of modern drugs there are still many unknown hazards. In 1962 after the foetal effects of thalidomide were published, the College of General Practitioners set up a pilot study to collect notifications about unexpected toxicity or benefits, which followed the use of any new or established drugs. Later, when the

Dunlop Committee began its national collection of similar reports, the information in our register was passed to them and our separate notifications ceased.

Like therapeutics, the origins of epidemiology are lost in antiquity. Man must have puzzled over the clustering of whatever came before measles, chicken-pox and mumps. Eventually the idea must have dawned that a disease which was brought into a community from outside by a stranger could then spread to others. In Northern Iraq during the war I saw this primitive epidemiology in action: a man rode out to meet me and my medical survey party three miles from a hill top town which we wished to study. He enquired about our health, where we had come from and if any of us had been ill recently. It was all most tactfully done as he returned with us towards the town. But if his suspicions about our health—or other matters—had been aroused, on a secret signal from him the doors of the town would have been barred against us. "Quarantine" was the means of keeping ships with infected passengers waiting outside the harbour for 40 days to see who else took ill or died; if all remained well the ship was allowed to berth. The modern international certificate of vaccination was developed originally to enable pilgrims from the Far East and elsewhere on their way to Mecca in ships, and later in aircraft, to travel onwards freely without this delay (Watson, 1938). In general practice we are gradually replacing quarantine by vaccination and education. And part of the research into vaccination against measles, for example, must be carried out by family doctors (Watson, 1965) because scarcely anyone with measles goes to hospital and because children catch the disease at home or in school, not in the wards.

In epidemiology we study the interaction between groups of people and a variety of other agents in a variety of environments. The "other agents" may for example be drugs or viruses, motor cars or cigarettes, or even man himself. General practice may be thought of largely as applied epidemiology. Family medicine is concerned amongst other matters with the interactions which develop within a household: the ill upon the healthy, the emotional upon the stable, adults and children upon each other. In so far as society itself is part of man's environment, which may at times and for some people be quite as traumatic as smoke dust, social medicine too comes into general practice. A general practitioner is at once personal doctor, family doctor and—with the growth of group practice—community doctor too.

In general practice more than in the wards or laboratory, nature carries out most of the experiments while the doctor watches and records. Those doctors who have completed worthwhile investigations have usually had to devise or adapt a suitable method of recording the information on which their results are based. James Mackenzie who created "cardiology" while in practice in Burnley elaborated a simple polygraph with which he took pulse tracings of patients under all manner of stresses and strains: for example, fever, accidents or during and after childbirth. (Mackenzie, 1925). Dr. William Pickles was able for the first time to identify the long incubation period of

infectious hepatitis because he kept elaborate and beautiful charts of all the various epidemics which affected his patients in and around Aysgarth (Pickles, 1939).

Modern continuous recording of morbidity by the members of the College of General Practitioners, and our search for new syndromes of congenital abnormality, are both dependant upon computer analysis but the principle remains the same. First an observation, then the development of ideas and the formulation of a hypothesis; a study is designed to confute or confirm the hypothesis and the long period begins of collecting and recording further observations; then follow tabulation, analysis, more time-consuming thought and finally a report —with luck, for publication. No wonder that proportionately few doctors, either in hospital or in general practice, bother much about research. Many well-founded observations lie dormant or are wasted because they are not completed by analysis, deliberation and reporting.

Some problems can be studied within the lifetime of one doctor working in one practice; others such as chilblains, which involve seasonal variables, can only be studied during winter, when other work is already increasing. Plans to study measles or influenza must be laid in advance of the next epidemic, which may however break without much warning. If regional differences are being considered, all the data cannot be gathered within a single practice; some form of collaboration with doctors in other districts must be devised.

The design of good research is an art which can be studied. Edited by Drs. T. S. Eimerl and A. J. Laidlaw, the College of General Practitioners has published "A Guide to Research in General Practice" (Research Committee, 1962). In any sphere it is difficult to bring constructive criticism to bear on one's own cherished ideas. The beginner in medical research would do well to show a draft of his proposed study to someone, whose opinion he would value, with a request for comments, suggestions and plenty of red pencil. If he can bear to see his hypothesis torn to shreds and replaced by a better one, and then go on to carry out his investigation, he has made a good start. Indeed, the educational value of research, in general or hospital practice, usually far outweighs any other results. Especially in single handed or isolated practices, opportunities for research are easier to come by than time for attending meetings or courses.

Carefully working out the aetiology of one difficult case can turn into an instructive and rewarding piece of research. It may involve a great deal of reading and discussion, sometimes even with specialists outside medicine. Collaboration between general practitioners of medicine and of veterinary science is only at its beginning; in years ahead we will see an increasing number of joint studies by these two branches of the healing art. After all, many of our "patients" share the same houses! Vets have been vaccinating our puppies against distemper for years, but we are only just starting to vaccinate the children, who look after these puppies, against measles—a virus related to distemper virus. Or again, a small patient of mine probably caught acute primary toxoplasmosis from her puppy, giving us one of the few timed incubation periods of the natural disease (Watson, 1962).

Some research in general practice depends upon direct collaboration between the family doctor and specialists, for example a pathologist. A problem may start in the laboratory but enough specimens cannot be collected quickly enough in one district. Finding rare specimens or patients with rare conditions for interested specialists is one of the tasks undertaken by the Epidemic Observation Unit of the College. In one such study, started in 1962, we are still alerting doctors to collect blood for serological studies at the P.H.L.S. Laboratory in Leicester, from patients recently found at operation to have acute mesenteric lymphadenitis. Records about severe cases of chickenpox in adults and about survivors of operations for childhood cancers are also being collected for other specialists. A register has been compiled of over 10,000 children born alive or dead between 1954 and 1960 with congenital abnormalities (Slater et al., 1964). Access to this collected data, now recorded on punch cards, is open to any research worker in the world on application to the College headquarters in London.

Several practices in Britain are carrying out a variety of special studies. In one, the Public Health Laboratory Service has established a laboratory in the surgery building to assist with virological studies (Hope Simpson, 1954). In many separate practices, comprising a research team, the practice records are now tabulated in a standard fashion for special retrospective studies. Another doctor uses punch cards as a routine and so is able to produce summaries of his work at quite short notice (Fry, 1961). In one group practice, records of different branches of each family are grouped in a special way to enable genealogical links between different chronic diseases to be recognised and studied (Kuenssberg, 1960).

Research into general practice can throw light on the uses which patients make of various parts of the Health Service. Studies in Manchester, Stoke-on-Trent and Stoke Mandeville are examples of operational rather than clinical research by family doctors. With the increasing number of people for whom each general practitioner is responsible each year, the need is urgent to study how best to use medical manpower outside as well as inside hospital. Every patient adequately kept out of a ward saves the country money. Every new tool put into use by general practitioners may alter his work load and increase his value to the community. For example, it is easier and quicker to carry out one cervical smear than to look after one woman dying of cancer of the cervix. But how many cervical smears must be done before one woman's life is saved?

As each new advance in medicine is digested, general practice constantly shifts away from diagnosis and mere management of increasing disability towards cure and then on to prevention. In my medical lifetime the introduction of liver for pernicious anaemia, sulphonamides and then the antibiotics for bacterial infection, steroids to reduce inflammatory reactions and simpler methods of haemoglominometry have each in turn altered the pattern of my practice, saving many people from admission to hospital and shortening their illness. On the other hand the rise of virology has increased my work and

also my interest in dealing with what my father would have dismissed as a "chill." Over 40 different types of virus have so far been isolated from patients in our practice with short previously undiagnosable febrile infections. We can now study symptomless immune reactions occurring among home contacts of those who show evidence of infection. A start has been made in studying that mysterious quality, resistance. Resistance precedes and may ward off infection; immune reactions can only start once infection has taken place (Watson, 1966).

Research and teaching are complementary. The next generation of family doctors should not have to start where the last began. The need is urgent to establish the teaching of research in general practice in many centres. The young medical graduate of to-day need no longer accept all he has been taught, or not taught, as gospel truth to the extent that James Mackenzie felt while he was in Edinburgh (Wilson, 1926). Like Mackenzie, he may struggle to learn for himself. How much better for Mackenzie and for the present day doctors if they could have found an opportunity to study research methods in general practice, as easily as the laboratory worker does. I for one am hopeful that this will come—quite soon.

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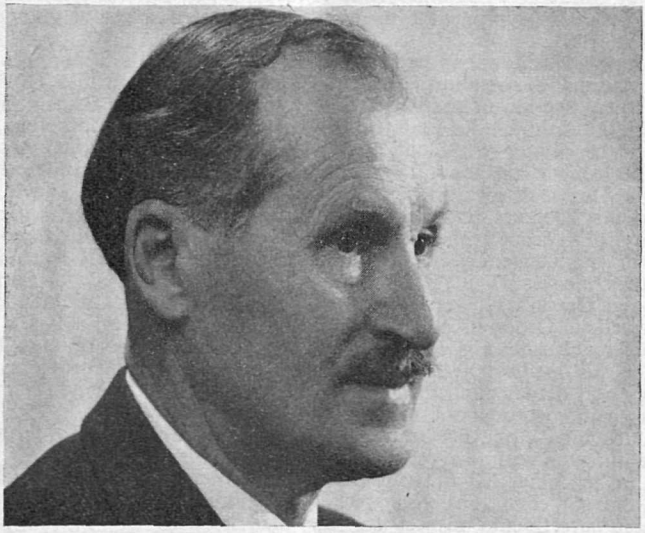
PROFESSOR M. A. RUSHTON

AN APPRECIATION



The retirement of Professor M. A. Rushton, two years before the normal time as a result of illness, has come as a shock to his many friends and professional colleagues, not only at Guy's, but throughout the country and also in other countries.

The son of W. Rushton, a dental surgeon, Martin Rushton was born on 29th March, 1903, and was educated at Gresham's School, Holt and Gonville and Caius College, Cambridge. He came to Guy's in 1924 to study for the dental course and the clinical part of the medical course and obtained the L.D.S.R.C.S. England in 1928, the M.A. and M.B., B.Ch., Cantab. in 1931, and the M.D. Cantab. in 1946.

After qualification he was dental house surgeon to Mr (later Sir William) Kelsey Fry and then in practice with his father in Harley Street, combined at first with a part-time demonstratorship in the Prosthetics department and then (1935-39) with his appointments as Assisant Dental Surgeon to Guy's Hospital and St. Thomas' Hospital. He was awarded the Colyer Prize of the Royal Society of Medicine in 1932 for the best original work published within five years of qualification.

During the Second World War he was Chief Dental Surgeon to the Plastic and Jaw Unit at Basingstoke and in 1946 was appointed Professor of Dental Medicine in the University of London at Guy's Hospital. His original work won him the Howard Mummery Prize of the British Dental Association in 1945 and the John Tomes Prize of the Royal College of Surgeons in 1954. He delivered the Charles Tomes Lecture of the Royal College of Surgeons in 1954, the Weinmann Lecture at the University of Illinois in 1960, and the Nuckolls Lecture at the University of California in 1961.

He was the Scientific Assistant Editor of the *British Dental Journal* from 1939 to 1946 and then Honorary Scientific Adviser from 1946. He was

Secretary, and later Chairman, of the Dental Committee of the Medical Research Council, and Chairman of the Board of Studies in Dentistry of the University of London from 1955 to 1958. He is a Senior Trustee of the Dentists' Provident Society and a Vice-President and Trustee of the Medical Protection Society. In 1956 he was appointed the London University representative on the General Dental Council, and has been Chairman or a member of several of its Committees and Sub-Committees. He has been a member of the Central Health Services Council and of its Standing Dental Advisory Council and a member of the Dental Sub-Committee of the University Grants Committee. He was a member of the Faculty of Dental Surgery of the Royal College of Surgeons, England, from 1948 to 1964, and its Dean from 1959 to 1962. He was appointed a member of the Board of Governors of Guy's Hospital in 1963.

Professor Rushton has been President of the British Dental Association, the International Association for Dental Research and its British Division, the Odontological Section of the Royal Society of Medicine, the British Society for the Study of Orthodontics and the British Society of Periodontology, and he has been the Senior President of the British Dental Students' Association. He has been made an Honorary Member of the Danish Odontological Society, and of the Dental Associations of Sweden, South Africa, Egypt and Malta.

Honours, Degrees and Diplomas have been conferred upon him by the University of Toronto, the Royal College of Surgeons of England and of Edinburgh, the University of Stockholm, the Royal Dental College of Copenhagen, the American College of Dentistry, the Royal College of Surgeons of Ireland and Queen's University, Belfast. He was made a Commander of the Most Excellent Order of the British Empire in 1960.

Professor Rushton is an able and modest man whose opinion has been sought by his medical and dental colleagues not only on problems of oral pathology and dental medicine but also on matters of dental policy in schools and Universities throughout the country.

His teaching clinic at Guy's has, for many years, attracted both undergraduate students and also postgraduates from other schools and his engaging manner of teaching, his humour and remarkable knowledge, particularly of unusual clinical conditions, has provided a stimulus to students and has also engendered affectionate respect for the man himself.

He has built up the department of Dental Medicine at Guy's and attracted men of high calibre, who had obtained their initial qualification at other schools, to work with him. He was one of the founder members of the British Division of the International Association for Dental Research and has throughout its 15 years of rapid growth guided it by his sound advice, and by his outstanding personal attributes created a fine image of Dental Research. He was the first non-American to be elected President of the Association.

In recent years, whilst he has occupied various posts of honour, many have enjoyed his thoughtful addresses and also his after-dinner speeches, which, delivered in an easy manner, have always been dignified yet humorous and have shown real feeling for the use of words. His originality of thought and charm of manner would have carried him far in any profession but we are indeed glad that he chose to grace the dental profession. These qualities have endeared him to many people both in this country and abroad where his scientific work, which has covered a wide field in dental medicine and oral pathology with publication of about one hundred papers over a period of thirty-five years, has won him widespread recognition.

Professor Rushton has always been a delightful companion whether on a ski-ing holiday, a conference, a visit to an art exhibition or to a dental school. In conversation he often surprises his friends by his knowledge of art or of the habits of some rare plant or animal, or history of some ancient monument. He is a keen gardener and always has something of special interest both in his garden and in pot plants in his house.

The early retirement of Martin Rushton is a great loss to Guy's and also to the Dental Profession which he has served with such distinction. We are glad to hear of his improved health and wish him many years of happy retirement with his wife Dorothy and his daughter Elizabeth.

W.E.H.

NOTICE

Dental Society Annual Ball

Guy's Hospital Dental Society are holding their Annual Ball at the Europa Hotel, Grosvenor Square, on Friday, November 4th. Dinner at 8 p.m. for 8.30 p.m. Dancing until 2.0 a.m. to Bill Saville's Orchestra, a steel band and the "Two of Each". There will be a cabaret and a raffle. Double tickets are four guineas for students and five guineas for new students, and can be obtained from K. A. Eaton (Ball Secretary) or Peter Hunt (Assistant Ball Secretary). Tables for dinner will be in tens and twenties, and applicants are asked to state whom they would like to sit with.

K. A. EATON (Ball Secretary).

CORRESPONDENCE

Politics are Natural to the Gazette

SIR,—I would like to write in support of Mr. John Leaming's letter in the last number of the *Gazette*.

Mr. John Leaming was a contemporary, and I remember a friend of mine at Guy's thirty years ago. I ought to have some reluctance in saying that I have always felt that as a New Zealander I have always felt rather snobby about the South Africans because of the really ghastly hash they have made of their coloured problem. After Mr. Leaming's letter, I see that our New Zealand Maori problem was miniscule compared to that in South Africa. I see also that it was made for us all the easier by the excellent public image of the Maoris contributed by such as the affable and highly efficient, muscular George Neapia. Nor did I make any reasonable allowance for the great contributions to the standards of living which the white South African had made for the coloureds.

I have been very well aware of the harm that half-baked liberalism with its do-goodism can do and has done all over the world. It was with relief that I read the Asquithian letter in the *Times* by Sir Douglas Logan showing that an academic can, however, on intellectual matters such as the responsibility of University Staff to established governments, in this case in Rhodesia, give a clear guide on difficult and complex subjects.

With Mr. Payne's letter I am in complete disagreement. He does not think that international politics should be debated in the *Gazette*. International politics are matters very close to the student. The *Gazette* is an influential consistently appearing world-wide journal. Politics are natural to it, but there have always been Guy's men who felt it should keep away from political matters. Thirty years ago the Peace Pledge, a typical piece of do-goodism, did grave harm to my generation. It was supported amongst others by a much beloved physician at Guy's. Partridge and I were then Editors of the *Gazette*, and in our own way failed him and all that the Peace Pledge stood for. There were many on the Staff at the time who deplored the line we took. But I am quite sure that we were right to debate the matter in the *Gazette*: albeit, it meant being pretty rough with, as I said, a beloved member of the Staff. Today I have no regrets except the limited success of our campaign in stopping the Peace Pledge, which in fact killed many thousands of my generation.

I thought Leaming's points about the value of Guy's methods of documentation by personal experiences were excellent.

Yours, etc.,

PATRICK CLARKSON.

107, Harley Street,
London, W.1.

The Starting Remark

SIR,—I little thought that my advertisement for an assistant and future partner to succeed me in my dental practice " in this land of sunshine and promise " would elicit a letter in the correspondence columns of your esteemed *Gazette*.

Dr. Stafford-Clark writes with great sincerity and humanity, and I find myself through the use of the phrase " land of . . . promise " in the unexpected rôle of defender of my country's policy of separate development.

I ask Dr. Stafford-Clark to believe in the sincerity and humanity of Dr. Verwoerd and his Government. I would like Dr. Stafford-Clark to visit South Africa and stay with me. I would like to show him just a little of what has been done and what is being done to improve the lot of our millions of primitive peoples speaking many different languages and belonging to many divergent ethnic groups who would soon be at each other's throats and in dire straights but for the guidance and protection of the white man.

Many of us are unhappy at some of the measures which have been taken to deal with subversive elements in our midst, but we live in a state of emergency and in such circumstances, as in warfare, drastic measures are sometimes necessary.

I was born and bred in England and started my professional career 40 years ago in dental practice in Alexandria, Egypt. Then, for several years, I practised in London, but finally decided to make South Africa my future home. I and my family are proud to be South Africans; we love our country and *all* its peoples.

So far from there being " a monstrous evil and injustices " and " the increasing possibility of civil war", the reverse is true. We enjoy a greater measure of peace, harmony and prosperity than many other countries of the world.

To know the history of our country is to understand that our problems are vast and unlike those of any other country. The realities of our situation cannot be met by the sudden application of ideal methods and measures. " Rome was not built in a day." We have the will, we have the means and we claim we have the know how. Give us time, reserve your judgment and let feelings of hostility give place to more tolerance and a better understanding.

Yours, etc.,

CLIFFORD PEDLEY, L.D.S., R.C.S.Eng., F.O.S.(S.A.).
1410, Rand Central,
Jeppe Street, Johannesburg, South Africa.

Some Support !

SIR,—If Dr. Stafford-Clark is to be attacked for making a public protest against racialist policies, may I, please, be allowed to join him? To me the idea that a person's opportunities in the community are to be pre-determined by his racial origins is thoroughly wicked. I think, also, that the incorporation of this idea into government may well lead eventually to the destruction of mankind.

Yours, etc.,

Prof. G. A. D. HASLEWOOD.
Biochemistry and Chemistry Department,
Guy's Hospital Medical School,
London, S.E.1.

. . . and some more !

SIR,—I was born and brought up in South Africa, and have followed the correspondence in the *Gazette* with great interest and considerable sadness. I can understand the rationalists of white South Africans living in that country, and I also know from my limited experience, that medical men, as a professional group, are among the most humane and decent in their treatment of Africans.

There are, however, one or two points which I should like to make. It is incorrect to state that the " Bantu is better off economically than is the native in any other part of the country." Relative to its resources, South Africa has

done less for the African than any other country. The reserves to which Africans are relegated, contain less than 14% of South Africa's total land. These areas are, as everyone knows, meagre in natural resources, backward, primitive, and far from the centres of industry. The remaining 86% is for white occupation only. The millions of Africans who supply the country with its labour, are temporary sojournors, and when they are no longer of any use, are frequently sent "home."

While white taxpayers' money may be used for the running of a hospital, Dr. Leeming must also, no doubt, be aware of assorted taxes which are imposed on Africans throughout South Africa.

As for peace, South Africa has one of the highest prison populations in the world. One out of every 236 South Africans is behind bars, and this has nothing whatsoever to do with Communism, but has mainly to do with pass-book offences. Alan Paton has called this process of mass intimidation "The finest blend of cruelty and idealism ever devised by man."

The main issue which is at stake, however, is that by virtue of the colour of a man's skin, he is doomed to inferior status and second class citizenship, with all its manifold ramifications, and this is "the monstrous evil and injustice" which is being perpetrated in South Africa.

If it were not for individuals of the courage, integrity, and breadth of vision of Dr. David Stafford-Clark and others, there would be little hope for the future peace of mankind.

Yours, etc.,

FAY LEZARD (Miss),
Senior Clinical Psychologist.

Department of Psychological Medicine,
Guy's Hospital.

One man one full stomach

SIR,—I take strong exception to Dr. D. Stafford-Clark's letter in the *Gazette* of July 9th, 1966. His statement deputing "monstrous evil and injustice" under Dr. Verwoerd's Government is ludicrous, while there is more risk of civil war in his own country than in South Africa. Law abiding citizens in South Africa, whatever their race or colour, have nothing to fear; it is only those who seek to undermine the State who are detained and put under restriction. The average Bantu in South Africa does not desire "one man, one vote"; he is far more concerned with "one man, one full stomach" which he knows he has more chance of attaining under the present Government. Anyway, if he has politial ambitions he can attain them in his own country—Bantustan, e.g., Transkei. Perhaps Dr. Stafford-Clark could visit South Africa as guest of the South African Foundation and see for himself that his dogmatic statements are unfounded and that South Africa is surely not the Nazi police state as claimed by the jealous and ignorant members of the Afro-Asian countries who have taken over control in U.N.O.

Any country in Africa which thinks it can "fly" before it has learned to "walk" and has been granted independence with "one man, one vote", has deteriorated—Nigeria, The Congo, Ethiopia, are but a few examples. No country in Africa has hospitals to compare with Baragwanat in Johannesburg, where every modern method of treatment is available to the Bantu. Posterity will prove that Dr. Verwoerd and to a lesser extent Ian Smith, in Rhodesia, though no less in importance, saved Southern Africa, from a return to the dark ages.

H. RONALD UNSTEAD, L.D.S., R.C.S.Eng., 1941.

110-111, 11th Floor, Trust Buildings,
Gardiner Street, Durban.

My Country—White and Wrong

SIR,—It is with a sense of profound and sincere regret that I notice that these words are, seemingly, becoming the traditional way of beginning letters to the *Gazette*.

To be truthful, however, it is with a sense of growing distaste that I have watched the "South African Promise" correspondence in the *Gazette*. Dr.

Stafford-Clark's letter, like most, well-meaning, and like all ill-meant criticism of the South African situation, is wholly without beneficial effect. The supporters of Dr. Verwoerd are largely beyond redemption. The tragedy is that so many people who were in opposition to him have been forced by external opinion into at least token support of the regime, and for wholly understandable motives—call them Ego-defence or tension-reduction mechanisms if you please. From all sections of the British Press and from nearly all other media of exchange of opinion between the two countries, they have been subjected to a sticky flood of the self-congratulatory whimpers of morally outraged pubescence. In the midst of this torrent of conscience-satisfying cant, the lonely letter of one very distinguished man can hope for no useful result.

It is like that early gem of mytho-physiological literature, the story of the shepherd boy who cried "Wolf and Wolff!" (1947). Accustomed to finding British opinion, as reported in the press, hideously misinformed, they cannot be expected to recognise sincere and informed criticism when it makes its rare appearance.

Dr. Stafford-Clark will have noticed already how his expression of a point of view—defensible, even if not balanced—has produced, in succeeding editions, letters displaying that frame of mind into which even men of high intelligence and moral integrity may be forced when self-preservation seems to be at stake, and one feels utterly alone in a hostile world. Under such conditions ill-informed British criticism and the political blunders of a succession of British Governments (especially the present one) have literally driven thousands of members of what once was an Opposition to seek support and assurance from the granite figure of the late Dr. Verwoerd, archetypal father-figure.

Dr. Stafford-Clark's later objection to the term "Bantu" is unjustified. While it is etymologically unsatisfying to anyone with a smattering of Zulu, it is preferable to most of its alternatives. He nimbly quotes South African and Rhodesian synonyms for this term, but very noticeably omits the highly emotive British slang equivalents in such wide use.

The origin of this mammoth correspondence (so suitably timed to revive some interest in the *Gazette's* flagging powers) largely overlooked by the correspondents, was Dr. Stafford-Clark's objection to the terms of a Personal Ad in which a South African dentist advertised for an assistant. A smoke-screen of political debate has been laid, largely between people not qualified to give a balanced opinion—either British and lacking personal experience and knowledge of the situation; or South African and lacking that breadth of vision gained by experience of the outside world. The true answer to the original objection was provided by Mr. Lewis. A peaceful and just settlement of South Africa's problems can only be hastened by the entry of enlightened men and women. To suggest as Dr. Stafford-Clark appears to (although it is difficult to discover, on re-reading his first letter, just what it is he would propose) that the unfortunate dentist should continue to lack assistance and that the country should lose the chance of gaining an enlightened doctor, is unworthy of him. Surely I must be misunderstanding him.

Yours, etc.,

J. CRESSWELL.

South Africa and
London, W.8.

From Black Bantustan

SIR,—The laws of a country are meant to be obeyed. Those who break them or actively engage in organising societies with the intention of so doing, must face the consequences. All of us in this country are very unhappy over the avowed intention of the Central African Black States to destroy the white man in Africa. This is fact. Any white man north of the Zambezi is there only as long as it suits the black government of the state concerned. All over is heard the cry: "When will the whites in South Africa change their ways?" My answer, sir, is when the black man reaches our standard of civilisation, not the text book education, which, I am afraid, is going to take a long time.

It is tragic that so many are guided solely by what is written, in self-pity, by the very few who have taken it upon themselves to set this country

in order, as long as it is their own order, which is anathema to the majority of us. We are amazed at the misrepresentation of facts by overseas newspapers.

The last time foreign troops were upon our soil was in 1899—they were English. Recently, well-trained saboteurs crossed the border of South West Africa, armed and with the intention of indulging in a little arson, rape and slaughter. Do the English folk approve of this? Do you really believe these people came over to free their enslaved brethren? Surely you can see they want to create what has happened all over Africa. Chaos and panic, until the United Nations intervene.

Before you in England completely believe that only van Rensburg, Mbeki, Joseph and First are correct, please make some small effort to find out the other side of the picture. I doubt the evidence is available. Your newspapers have seen to that.

We all dislike these laws intensely. But they have proved to be the only way of stopping what we don't much like. The destruction of our organised Government. The 3rd round in this process is about to begin. From what Dr. Stafford-Clark and Dr. Levitt write, I gather they feel it must not be stopped nor prevented. Regret I can't agree.

Overseas capital is pouring in. Would this happen if there were no confidence for our future, or civil war were imminent? Two questions: What do you think will happen when the Asian Hordes pour into Australia? What would you people do if one hundred and seven million non-whites entered Britain and tried to take over your Government?

I sign off, refusing to apologise for being white.

Yours, etc.,

DR. T. R. WOOLDRIDGE.

Tsomo,
Transkei, South Africa.

A Final Word?

SIR,—As a Canadian visitor of Hungarian origin who was at the receiving end of both the Nazi and Communist dictatorships, may I be allowed to add the following point to the correspondence following Dr. Stafford-Clark's letter in the pages of the *Gazette*.

During the Thirties the lot of the working man in re-arming Germany was certainly better in terms of employment than in Britain beset by the depression. It is amazing how similar the style and logic of the defenders of totalitarian views are, be they in Germany, Britain, America, the U.S.S.R., Hungary—or in South Africa.

Yours, etc.,

THOMAS R. CSORBA, M.D., Ph.D.

Department of Medicine,
Guy's Hospital Medical School.

A doctor's place is in the home

SIR,—May I be permitted to quote part of a sentence out of Passim (20th August) not in context, to illustrate a point?

"General Practice has come to be regarded as the poor relation, the branch of service that attracts only those with limited intellectual and professional ambitions."

Let me now refer you to the somewhat limited intellectual and highly vitriolic correspondence between "old friends" and "colleagues" at Guy's, regarding South African political disputes.

One has, of course, one's personal views on international matters, but this correspondence should never have been started by members of a scientific and humane profession.

The vast number of the lesser breed of medical and dental graduates who enter General Practice realise early on in their careers that they are advising and helping in the problems of individuals and their families, and that troubles and disputes cannot be divided down the middle into the good and the bad,

the just and the unjust. There is such an enormous chasm between both extremes which is governed by the social and moral views of the time. The outlook of people changes over the years and one must consider such things from an historical point of view.

The medical graduate is merely concerned only with the person and his local environment; the politician with the group or nation, and the power that accompanies this in all its terrible aspects.

Let these " intellectual and ambitious " men go into General Practice for a year and begin to learn the humanities. The Medical Politician is potentially a very dangerous animal, and as a reader of the *Gazette,* I want none of it.

Yours, etc.,
W. M. SHEERAN, L.D.S., R.C.S.(Eng.)

262, Portland Road,
London, S.E.25.

Letter from an American

SIR,—In response to "Passim" in the *Gazette* of August 20th, and as a way to hopefully enlarge upon the statements made there, I would like to record some of my impressions from an all-too-brief stay at Guy's.

Now that the summer invasion from across the ocean is almost over, I would like to take the opportunity to thank Guy's Hospital and Guy's men for the fine welcome and hospitality which they have shown towards us. I know I speak for all the "Yanks" who are here this summer as visiting medical students when I say we have found our stay quite rewarding in many ways. Educationally, we have been exposed to a somewhat different approach to teaching and in some ways to the patient as well; we have also been able to observe the National Health service with all its benefits and shortcomings; in addition we have gained many friends and we all hope they have gained a little more understanding of Americans.

Guy's is a fine hospital and Medical School and we are all impressed with the caliber (sic) of medicine practised here. From what I have observed, a great deal of emphasis is placed on teaching students both by the registrars and consultant staff. This is a feature of Guy's which is not fully appreciated by the students. There is a tradition in medicine throughout the world that the experienced physicians should give freely of their knowledge to those learning medicine. This tradition is, I believe, being carried on at Guy's in the fullest sense of the word. Although consultants vary in their personalities and teaching abilities, they all carry on regular rounds and take an active interest in teaching. The registrars provide a fine link between the consultants and the students, and my experience has been that they are enthusiastic teachers and fine physicians. Thus, the opportunity to learn is certainly here at Guy's, but the burden is on the student to show initiative. The students on the whole are very capable, but some do not take full advantage of the opportunities available to them. The system is much more relaxed in certain aspects than the great majority of American medical schools. I refer especially to examinations which come after a great interval of time and are all important in their consequences. We are, in general, given examinations with a greater frequency. This provides an artificial incentive to keep up with our work. Here the tendency is, I believe, often to relax until examinations approach, and then try to cover a great deal of ground in a short time. This, of course, is not unique to Guy's, but is convenient; however, it is somewhat easier to pursue this approach here. Too often students fail to read along with their clinical work. Those who respond to the intellectual challenge benefit immensely as shown by the capability of the registrars and many housemen as well.

The patients receive excellent care from the fine nursing staff, the wards are very clean, and the hospital seems to be run very well. In some respects, the benefits which patients receive under the National Health service are cancelled out by the financial difficulties involved in acquiring the latest in technical equipment and in inducing younger doctors to remain in their native country. The latter point has been made painfully obvious of late and needs no further comment.

The students themselves were most helpful in our orientation, and many took the trouble to know us in greater depth. This feeling of friendship was

greatly appreciated and was one of the most important things in making this a wonderful experience.

My thanks to Guy's men and to the hospital for allowing us to work here. I hope that many students from this school will have the opportunity to observe the way we practise medicine. I hope to return some time in the near future.

Yours, etc.,

MARK J. WEISS.

East Wing Guy's and
Temple Medical School,
Philadelphia, Pennsylvania.

Not Cricket

SIR,—It was with profound regret that we noted the bitter attack levelled by P. G. F. Swift at the Cricket Club in the last edition of the *Gazette*.

We do not feel that the *Gazette* is the right place for a clash of personalities to be aired, and in so doing publicly degrading the name of the Cricket Club.

Any such injustices which he may feel have been manifested against him or any other player we would be only too pleased for him to raise at the Annual General Meeting.

Yours, etc.,

D. G. A. SILK,
S. DAVOODBHOY,
D. P. G. GRIFFITHS,
Selection Committee, Cricket Club.

Guy's Hospital,
London, S.E.1.

NURSING SECTION

Nursing Shortage

In view of the publicity given to Guy's in recent weeks, the *Nursing Times* published an interview with Matron and the Principal Nurse Tutor. A summary of their discussion follows.

Do you regard the present difficulties as being solely due to a shortage of nursing staff?

Certainly not. The increased pressure of work in the last two years alone, has been carried without any substantial increase in supporting staff, and with no increase in trained nursing staff. Our bed numbers have remained the same yet, while in 1963 we treated 14,700 in-patients, in 1965 16,400 passed through our hands. A similar increase has been shown in the number of operations and in the number of out-patients. The present situation presents a challenge to the whole of our hospital management.

Regarding the steps that have been taken:

An analysis of the whole situation has been made and will shortly be presented by the Chairman of the Nursing and Nurse's Education Committee to the Board of Governors. For the immediate action the Chairman directed that these steps be taken :—

(1) The practice of using "extra" beds shall cease.

(2) Operating sessions shall be limited to the hours between 8.30 a.m. and 1 p.m. and 2 p.m. and 6 p.m., with the obvious exceptions of emergency requirements.

(3) For one week from September 4th, 1966, three wards will be closed. This is because, with the requirements of the student nurses' training programme and the shortage of trained nursing staff for clinical work, it is impossible for us to give adequate care to all the patients for whom we could offer accommodation.

Does this mean there are too many nurses in training?

No. Just at this time we are experiencing the effects of having, a year ago, changed from one training plan to another, in order to implement the 1962 syllabus of the General Nursing Council, and we have an imbalance in numbers of first-, second-, and third-year students available for clinical experience. It is imperative to have a smooth and regular intake of nursing students, annually, and that this should be continuous policy.

Regarding the limiting factors to the numbers of student nurses whom Guy's can train:

(a) Any hospital will always be limited by the amount of specialized clinical experience that it can offer, without seconding students away from the parent hospital to an unreasonable degree. With other hospitals now in the Group, Guy's has just the right amount and type of clinical experience available for the 700 nurses in training.

(b) Any nurse training school has its intake limited by the amount of physical space available in the school of nursing. There must be enough room for the students to sit for lectures, for study; and for discussion groups.

(c) Perhaps most important of all is the availability of an adequate number of trained, supervisory nursing staff in the wards to support the students.

Regarding ready co-operation from the medical staff in limiting the number of operating sessions:

Every individual is keenly anxious to maintain the standards held in less problematical years.

Regarding the recruitment of supporting staff, such as domestics, porters and ward aides:

Guy's is situated in a non-residential area and this certainly provokes difficulties.

Apropos a question to Matron on the outcome of the new arrangements with respect to the responsibility of providing Guy's patients with a proper nursing service:

Miss Johnson, Matron, replied that she was convinced that the first steps taken were the right ones, in meeting our present difficulties. "We are all involved in this situation and everyone is aware of it. The chairman will soon be meeting the Sisters again to talk things over with them. We shall shortly be engaged upon a radical examination of all the hospital services, the laundry, portering, and the cleaning services as well as the nursing. As I said before, this is not just a nursing shortage—it is a problem which involves the best use of the hospital's total resources. The present difficulties are due to a combination of factors and I believe there is no problem which is insurmountable: I know that we shall prove that this present phase will be a turning point which will undoubtedly add to the triumph of Guy's—and, perhaps, also assist others elsewhere in making a realistic analysis of their own problems."

Sister Brysson Whyte, Principal Nurse Tutor, was questioned concerning her immediate responsibility to give the nursing students a proper training, fulfilling not just the requirements of the General Nursing Council, but matching up to the best traditions of Guy's nursing.

Sister Brysson stated that she was greatly heartened that the interests of the nurses in training have been safeguarded by the steps that have been quoted. "I am confident that our wastage rate, which is radically diminishing, will continue to improve steadily and more nurses on qualification, will stay with us."

Regarding present steps to retain the newly-registered nurses:

As soon as they are qualified we give them a study week to introduce them to their new responsibilities as staff nurses, and to have a chance of seeing the hospital as a whole. Trained nurses who join us from other hospitals as staff nurses, can join this study week and we always give them an individual

three-day orientation course. When sisters join us who haven't worked in Guy's before we give them a three-week orientation period before they take over their new wards or departments. All our sisters have two study days per year. We are, of course, working the 42-hour week, and this presents many problems.

Regarding the eventuality of having enough trained nurses:

This can probably not be envisaged. But this answer applies nationally as well as to Guy's. Teaching hospitals have special problems. Just as we train so many student nurses, accordingly we need a lot of trained nurses to supervise them. Then with the amount of medical research which is being pioneered, there are always special units which are extremely extravagant of traind staff. In isolation one patient can need as many as seven nurses to care for him—not all on duty at the same time, of course.

As a statement to the general public, who are, after all, potential Guy's patients:

Any society will only get the health service it is prepared to provide resources for, in both the vital factors of money and manpower.

Following the interview with the "Nursing Times", a number of steps have been outlined to the sisters by the Chairman of the Board of Governors. These proposals will come into force in the immediate future.

It is understood that the practice of using "extra" beds will cease for all time. This will take a great strain off the wards when they are at their most busy—especially during the winter months.

It has been arranged that the shortages of trained nursing staff should be supplemented by the employment of "Agency Nurses" to work in Nuffield House. They will relieve some of the trained nurses at present working on the private wards, who will then be transferred to Hunt's House. In Hunt's House the ward sisters who are at present working as part of the ward team, will be relieved in order to be able to work more for the welfare of the patients and also in their official capacities as administrators and teachers.

For some time it has been appreciated that the present staff shortages could be helped by the introduction of lay-personnel to the wards. A full-time organizer for voluntary help is now to be employed. This is to help the patient in his everyday non-nursing needs. These helpers would be for the patients primarily, although the nursing staff would be indirectly assisted. In addition to this, a staff nurse has been appointed to be responsible for the training and organization of auxiliary nurses in conjunction with Matron's Office. Further articles on these subjects will be published in future copies of the *Gazette*.

Further to the announcement that there are to be eight receptionists appointed to the medical wards, it has been possible at this early stage to appoint a further group of receptionists to work one on each floor of the surgical block—one between two surgical wards.

It is obvious from these announcements that the hospital management is quickly and efficiently solving or going a long way towards solving a number of problems that have cropped up during the last few months.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

S/N H. Hillhouse, to Evelyn Ward.
S/N J. Mitchell, to Sarah Ward (part-time).

CHANGES

Sister J. Flower, from the School of Nursing to Hurst Ward.

DEPARTURES

Sister H. Matcham, from Hurst Ward to the London School of Economics.
S/N S. E. Austen, from Patience Ward.
S/N P. M'Caw, from Bright Ward.
S/N V. M. Morris, from Theatres.

REVIEWS

" THE STRUGGLE FOR CRETE "

by I. McD. G. Stewart. Published June, 1966, by Oxford University Press, London. pp. 518. 21 illstr. 28 maps. *Price* 70*s*. net.

The emergence of a Guy's man as a major war historian is an event, and the reception already accorded to Ian Stewart's scholarly review of the 12-day battle for Crete by the literary critics confirms the Oxford Press judgment in accepting this considerable manuscript. It is a competent detailed analysis of the first—maybe the last—airborne invasion of history, a violent conflict of new tactics in which the traditional bravery of Greek, British, New Zealander —and indeed German once again bore tribute to their fighting qualities. Such an assault was bound to be costly in men, for never before had thousands of parachutists and glider-borne troops been dropped on to such a hornet's nest. The pity was that for lack of real preparation on the ground, indifferent defence armour, lack of air cover—and eventually of sea support, so complete was the Luftwaffe mastery, the island was not held, and a crushing defeat inflicted on the German forces. This is Stewart's theme, and well he supports it by a prodigious study and analysis of the enormous bibliography on the campaign, English, Greek and German: a " lost opportunity " indeed. Maleme, he avers, was the turning point, with an agate edge developing around May 22/3 on which the balance tipped in the invaders' favour for lack of constructive aggression: uncertainty was then rife in German circles, but information and communications were then in no state to enable Freyberg to know the position. One is reminded of Stephan Zweig's classic " Turn of the Tide ", in which delicately balanced turning points of history are reversed, and the outcome studied; and the author himself sees history repeating its tragedies.

Of the figures that emerge, Kippenberger—almost alone with high credit, Campbell perhaps, certainly a host of brave officers and men: but of the others, hardly Puttick, or Weston or Hargest—and perhaps least of all the great General Freyberg himself. Redoubtable, courageous, firmly in command when he could get into communication, tactically correct no doubt, but somehow too slow, too ill-prepared (though this was Wavell's fault, perhaps), ill-equipped—especially in radiocommunications (though he could have foreseen this as could Wavell from Egypt or the War Office in London), desperately short of air support and finally bereft of sea supply communications, so complete was German command in the end, Freyberg always seemed to be just too late, out of reach or on the retreat: he himself had lost by the third day, though desperately brave fighting went on for another week. All this Stewart portrays with a strong pen in firm decisive English that is easy to read in spite of the vast amount of factual information that had to be incorporated to support his critical evaluation of the day-to-day course of the struggle.

This is a fine book, very well written indeed in phrases of which Winston Churchill himself would have approved, and singularly lacking in officialese or Gowerish gobbledecock. Stewart knows what he is talking about, for he was there himself, and now that the heat of the battle has died away, he has written a definitive account of a great battle that bears comparison with that of any professional historian.

KEITH SIMPSON.

SPORT

RUGBY FOOTBALL

The winter season kicked off last Saturday in weather more suited for a cricket match. However, the sun stimulated the 1st XV to a very large and excellent win against Bromley, their customary opponents in the season's opening match. Guy's won by 36 points to 3, their biggest win in a club match since their defeat of Old Blues by 41—3 two seasons ago. In the first half many mistakes were made not unnaturally, and Guy's led by 6 points to 3 (two penalty goals to one) at half-time. However, in the second half, Guy's ran away with the game, scoring several fine tries. Unfortunately, Thorburn was carried off the field about twenty minutes from the end with torn ankle ligaments which will keep him out of the game for at least six weeks.

Of course, Guy's are expected to beat Bromley quite easily each year, but a big win at this stage should not instil overconfidence in the side, particularly with the stronger fixtures to come during the coming months. During the next two weeks Guy's play Blackheath and Old Askeans. Guy's have not beaten Blackheath for many years, but played very well last year to draw at eleven points each. Very surprisingly, Guy's have never beaten Old Askeans, having lost twice and drawing last year, after having led 17—8 with but a quarter-of-an-hour to go, since the fixture was introduced three years ago.

With the basis of last year's cup winning side, Guy's should look forward to another good season. As always, the ultimate aim is to win the cup, but this will only be achieved by building up the confidence and belief in themselves which will only come with success in club matches. In Thorburn, Guy's have a captain who can not only lead his side through a successful season, but could become the first International at Guy's for many years. He was so close to the Scotland side last season that his first cap cannot be very far away. His injury in the opening match is most unfortunate, but to him and his side we wish the best of luck for a good season.

FOOTBALL

The Soccer team do not start their season for another two weeks, when they have a series of pre-term matches. Last season Guy's won the Hospital's Cup with a side that was given no chance at the beginning of the season. This only goes to show what can be done when a side is enthusiastic and plays above itself. The same could happen again this season.

HOCKEY

The Hockey Club were disappointing last season with a rather poor performance in the Hospital's Cup. However, Guy's have the basis of last year's side, and with the experience gained last season, could develop into a good side capable of regaining the Cup. The Club also have a series of pre-term fixtures; also they are to have some training and coaching at the National Recreation Centre at Crystal Palace. Perhaps this will help the side fulfil the promise they have showed but never confirmed.

CRICKET

The cricket season finished a few weeks ago, but disastrously for Guy's, who suffered a heavy defeat at the hands of Old Alleynians. Guy's, with a much weakened side, were dismissed for under 50 runs when chasing a total of around 150. Butchey was unable to make the necessary runs to complete his thousand runs, which, if achieved would have been a superb performance. This miserable result against Old Alleynians brought to a close a rather disappointing season. The weather was unkind during the tour, but the team were rather unpredictable throughout the season, particularly the bowlers, who sometimes had difficulty in containing the opposing batsmen. The team batted

badly against St. Thomas's in the semi-final of the Cup, even allowing for a poor wicket, but full credit to St. Thomas's, who thoroughly deserved their win in the final against St. Mary's.

Guy's cricket has not progressed as it should have, largely because the team lost a large number of the successful side of a few years ago all in one year, and replacements of the same calibre have not been found.

SPORTS DIARY

RUGBY UNION.

September:

Sat., 17th—Blackheath. Away. 3.00.
Sat., 24th—Old Askeans. Home. 3.00.
N.B.—Sunday, 25th—Streatham/Croydon Sevens.
Guy's v. Northampton. 3.00 p.m.
(1st games, 2.20 p.m.)

SOCCER.

September:

Sat., 17th—Icarus. Away. 3.00.
Sat., 24th—Manor Sports. Home.

HOCKEY.

September:

Thurs., 22nd—Purley. Away. 6.00 p.m.
Sat., 24th—London Hospital. Home.
Wed., 28th—Habari. Home.

LAWN TENNIS

The last match of the tennis season proved to be much the most satisfactory. This was a triangular fixture with Tunbridge Wells and Sussex Under-21s. Each side produced two pairs and each pair played two sets against all the opposition pairs. Thus, everyone plays eight sets. It was agreed at the beginning that the proportion contributed to the beer kitty should depend on the team's finishing position. Guy's members were distinctly worried by this idea but it possibly spurred them on to play better tennis than would otherwise have been the case! Apart from one bad lapse when they let slip a 4—0 lead, Hopkins and Newman played better than for the rest of the season, winning two and drawing their other two matches. The second pair managed to draw two of their matches, thus putting Guy's into 2nd place behind Tunbridge Wells.

Although only half the matches have been won this year the season has been satisfactory. Last year practically all our matches were won easily, so the fixture list was strengthened accordingly. None of the new fixtures against club sides were won, which emphasises the large difference in standard between club and college tennis. These losses were partially due to the fact that only on three occasions during the season was the whole 1st VI playing. Even so, the club maintained a creditable record in college tennis. The Inter-Hospitals' Cup was retained, the United Hospitals' Singles Cup was won and the London University Singles Cup was halved; bad weather preventing the final being played.

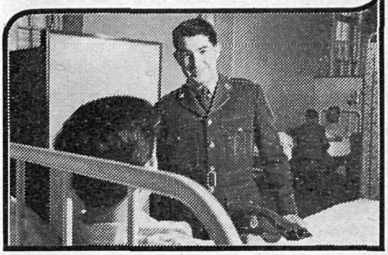
Several of the 2nd VI did well when playing for the 1st, and the team also stressed Guy's superiority in hospitals tennis by beating other hospitals 1st teams. For the first time a mixed match was arranged. This probably provides a more enjoyable afternoon's tennis for the 2nd VI than does a men's match, and I have yet to meet women who really enjoy women's doubles, so this side of the fixture list could do with enlarging.

Five members of the first team hope to be available next year, so there should be a reasonable chance of retaining the hospitals' cup, and if we can turn out a full first team regularly we should improve our record against club sides.

J. H. NEWMAN

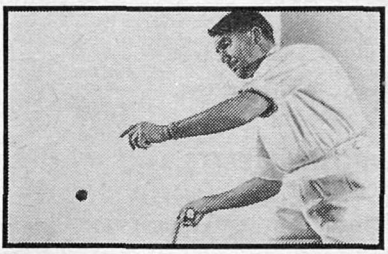
A doctor's life with a difference can be found in the

ROYAL ARMY MEDICAL CORPS



The professional opportunities are very wide and varied and include caring for the wives and children of soldiers.

All aspects of medical care—preventive medicine, general and hospital practice are closely integrated. Surgeries are organised by groups and groups are supported by hospitals. Medical Officers are able to follow up their patients admitted to hospital. Good equipment, trained staff, a locum for six weeks' annual leave, and post-graduate training are provided. For the married man it matters greatly how his wife feels about the Service. Marriage Allowance, Education Allowance, Disturbance Allowance, and Local Overseas Allowance, show the importance attached by the Army to helping



the Officer with a family. Most married Medical Officers get a furnished house at low rental.

Pay for a married Captain (the rank on entry) is over £2000. There are increases every two years and on promotion. Promotion to Major comes normally after 5 years and to Lieut-Colonel after 13 years (or shorter, where an antedate is given for experience in hospitals and general practice). Commissions granted may be permanent or Short Service. A Short Service Commission earns a tax-free gratuity of £3000 for 5 years' service, £1500 for 3 years. Regular commissions are pensionable on the normal basis. For further information please write or pay a visit to: Colonel A. D. Young, D.S.O., M.B., Ministry of Defence (AMD2), Dept. 426, Lansdowne House, Berkeley Square, London, W.1.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

BOARD OF GOVERNORS OF GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD.

Registrar in Psychiatry.

Applications are invited for the above post to be held jointly at St. Olave's Hospital, S.E.16, and Bexley Hospital, Kent. The Department of Psychological Medicine at St. Olave's Hospital offers in-patient, day patient and out-patient facilities in a busy general hospital. Opportunity will be provided for study and experience in developing community service involving links with Guy's Hospital. Experience in special problems and rehabilitation will be provided at Bexley Hospital, which is a modern adult psychiatric hospital.

Candidates may be resident or non-resident and should have previous psychiatric experience. Appointment from 1st November, 1966, to 30th September, 1967.

Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **30th September, 1966**.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Part-time (6 sessions) Senior Registrar to the Dialysis Unit,** vacant on 1st October, 1966. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **24th September, 1966.**

GUY'S HOSPITAL DENTAL SCHOOL.

Applications are invited for the post of **full-time Lecturer** in the **Department of Dental Prosthetics.** Salary in the scale £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535 with superannuation. Appointment to date from 1st November, 1966. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Tuesday, 4th October, 1966.**

APPOINTMENTS

GUY'S HOSPITAL.

JUNIOR STAFF APPOINTMENTS, 1966/67.

The following appointments and re-appointments have been made by the Board of Governors for the period beginning October 1st, 1966.

WHOLE-TIME APPOINTMENTS.
MEDICAL.

Medical Registrars.
Dr. R. K. Knight.
Dr. I. D. B. Rennie.
Dr. J. R. R. Spurrell.
—
Dr. C. N. Mallinson (on unpaid leave).
Dr. R. D. Hill.
Dr. McHardy-Young.
Dr. C. J. Hughes (New Cross Hospital).
Dr. C. S. Ogg (St. Olave's Hospital).

Junior Medical Registrars.
Dr. A. D. Milner.
Dr. H. D. Tunstall-Pedoe.
Dr. W. J. Appleyard.
Dr. A. L. W. F. Eddleston.

Surgical Registrars.
Mr. J. D. Maynard.
Mr. I. McColl.
Mr. S. A. R. Cooke (seconded to Medical School).
—
Mr. B. A. Ross.
Mr. R. C. L. Feneley.
Mr. W. G. Hartfall (St. Olave's Hospital).

Junior Surgical Registrars.
Mr. C. B. T. Adams.
Mr. F. D. H. Birkett.
Mr. A. Dowlatdad.
Mr. A. N. Nicolaides.

Registrars in the Throat and Ear Department.
Mr. G. A. Toma.
Mr. J. A. S. Carruth (at Lewisham Hopital).
Mr. J. M. Fox.
Mrs. C. Wengraf.

Obstetric Registrars.
Mr. E. P. W. Tatford.
Mr. J. D. Ellis.
Mr. M. F. Terry.

Cytologist.
Mrs. W. Ellis.

Registrars in Physical Medicine.
Dr. B. A. Latham.
Dr. J. Colston (in Region).
Dr. W. J. Cahill.
Dr. H. C. Burry.

Registrar in the Cardiac Department.
Dr. D. C. Fluck.

Junior Registrar in the Cardiac Department.
Dr. C. F. P. Wharton.

Registrars in Clinical Pathology.
Dr. P. A. Emerson (at Lewisham Hospital).
Dr. N. A. *Simmons (until 31.10.66).*
Dr. S. Amin.
Dr. C. J. Hunter-Craig.
Dr. J. L. Stanford.
Dr. P. A. Trott.
Dr. A. Sayeed (at Brighton Hospital).

Registrar in Haematology.
Dr. J. L. Raven.

Registrar in Endocrinology and Radioisotopes.
Dr. P. W. R. Harris.

Registrars in Psychological Medicine.
Dr. D. I. Brough (St. Olave's).
Dr. I. G. Christie.
Dr. J. D. Earp (Bexley).
Dr. A. C. Smith (Bexley).
Dr. B. A. Davies.
Dr. I. Abey-Wickrema.
Dr. M. C. Bott.
Dr. P. V. Nair.

Registrars in Child Psychiatry.
Dr. . A. O'Keeffe.
Dr. J. Ross.
Dr. P. A. Murray.

Orthopaedic Registrars.
Mr. M. A. Nelson.
Mr. S. J. Lam (St. Bart's, Rochester).
Mr. D. J. Richards.
Mr. A. L. Gunn (New Cross and St. Olave's).

Orthopaedic and Casualty Registrar.
Mr. P. C. Shaw.

Genito-Urinary Registrar.
—

Dermatological Registrar.
Dr. A. Bowyer.
Dr. J. L. Verbov.

Registrars in Diagnostic Radiology.
Dr. B. Cremin.
Dr. J. R. Barnett.
Dr. A. B. Dew.
Dr. B. C. King.
Dr. J. S. M. Beales.
Dr. N. J. Strickland.

Registrar in Radiotherapy.

—

Dr. M. Haque.

Registrars in Neurology.
Dr. R. G. Lascelles.

—

Junior Registrar in Ophthalmology.
Mr. S. H. Saunders.

Paediatric Registrars.
Dr. P. M. Zinkin.
Dr. S. R. Meadow.
Dr. L. Rosenbloom (at Brighton).

Registrars in Thoracic Surgery.
Mr A. K. Yates.
Mr. B. N. Pickering.
Mr. J. A. Dyde.

Registrars in Anaesthetics.
Dr. M. Lindsey.
Dr. G. D. Thomas.
Dr. R. R. Watkin.
Dr. P. W. R. Smethurst.
Dr. G. Gerson.
Dr. P. Hewitt.
Dr. W. J. O'Brian (Brighton).
Dr. B. R. T. Smith (New Cross and St. Olave's).
Dr. T. E. J. Healy (New Cross and St. Olave's).

Registrars in Geriatrics.
Dr. H. M. Gillespie.
Dr. P. Ashley (at Hastings).

PART-TIME APPOINTMENTS.

Registrars in the Ophthalmic Department.
Mr. H. P. B. Whitty.
Mr. E. W. G. Davies.
Mr. V. N. Highman.

Registrars in V.D. Department.
Dr. D. C. Hutfield.
Dr. J. J. Rohatiner.

WHOLE-TIME AND PART-TIME APPOINTMENTS.
DENTAL.

Registrars in Children's Department.
Mr. J. K. Luffingham
Mr. J. Metcalf.
Mr. S. I. M. Robinson

Orthodontic Assistant.
Mr. C. D. Stephens.

Registrars in Clinical Dental Surgery.
Mr. D. H. Gibb.
Mr. W. T. Lamb (from 1.12.66).

Registrar in Minor Oral Surgery.
Mrs. A. Robinson.

Registrars in Preventive Dentistry.
Mr. C. H. Forsyth.
Mr. P. D. Venning.
Mr. D. G. Stone.
Mr. D. W. McFarlane.

Registrars in Dental Casualty.
Mr. G. C. D. Ross.
Mrs. A. Robinson.

Registrars in Dental Prosthetics.
Mrs. A. Robinson.
Mr. A. G. Buchanan.
Mr. A. J. Stewart.
Mrs. H. M. Jones.
Mr. P. B. Morris.

Registrar in Conservative Dental Surgery.
Mr. R. C. Paterson.
Mrs. S. Roberts.
Mr. R. A. W. Wakeley.
Mr. G. G. Ashby.
Mr. B. D. Glynn.
Miss M. K. Prest.
Mr. R. A. Ellis.
Mr. D. J. Purdell-Lewis.

Registrar in Dental Radiology.
Miss V. Beaton.

Dental Officer to treat In-Patients and to Salomons Centre.
Mr. P. H. Chadwick.

R. J. CANN,
Acting Superintendent.

August, 1966.

GUY'S HOSPITAL.

Allocation of Medical and Surgical Registrars, 1966/67.
To take effect from October 1st, 1966.

Medical Registrars.

Dr. Mann and Dr. Scott.	Dr. I. G. McGill.
Dr. Hardwick and Prof. Trounce.	Dr. J. R. R. Spurrell.
Dr. Baker and Dr. Houston.	Dr. S. McHardy-Young.
Dr. Kauntze and Dr. Joiner.	Dr. R. D. Hill.
Prof. Butterfield and Dr. MacLean.	Dr. R. K. Knight.

Junior Medical Registrars.

Dr. Mann and Dr. Scott.	Dr. H. D. Tunstall-Pedoe.
Dr. Hardwick and Prof. Trounce.	Dr. A. D. Milner.
Dr. Baker and Dr. Houston.	Dr. W. J. Appleyard.
Dr. Kauntze and Dr. Joiner.	Dr. A. L. W. F. Eddleston.
Prof. Butterfield and Dr. MacLean.	Dr. C. P. W. Warren.

Surgical Registrars.

Mr. Eckhoff and Mr. Glover.	—
Prof. Atkins and Mr. Lawrie.	Mr. R. C. L. Feneley.
Mr. Wass and Mr. Brain.	Mr. B. A. Ross.
Mr. Blackburn and Mr. Beard.	Mr. J. D. Maynard.

Junior Surgical Registrars.

	October to March.
Mr. Glover/G.U.	Mr. A. N. Nicolaides.
Mr. Brain/G.U.	Mr. F. D. Birkett.
Mr. Beard and Mr. Crabbe. Neurosurgery.	Mr. C. B. T. Adams.
	Mr. A. Dowlatdad.
	April to September.
Mr. Glover/G.U.	Mr. C. B. T. Adams.
Mr. Brain/G.U.	Mr. A. Dowlatdad.
Mr. Beard and Mr. Crabbe. Neurosurgery.	Mr. F. D. Birkett.
	Mr. A. N. Nicolaides.

MEDICAL REGISTRARS AND JUNIOR REGISTRARS WITH DUTIES IN SPECIAL DEPARTMENTS.

Cardiac Clinics.	
Dr. Baker.	Dr. S. McHardy-Young.
Dr. Kauntze.	Dr. R. D. Hill.
Chest Clinic.	Dr. I. G. McGill.
Asthma Clinic.	Dr. S. McHardy-Young.
Diabetic Clinic.	Dr. J. R. R. Spurrell.
V.D. Clinic.	Dr. W. J. Appleyard.
Endocrine Clinic.	Dr. P. W. R. Harris.

August, 1966.

PERSONAL

HOVE.—FREEHOLD S/D CORNER HOUSE, large garden, 3 bedrooms, 2 reception, kitchen, bathroom. Downstairs and Upstairs Lavatories. £5,000.—Box No. 179.

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LONDON, W.1. Busy and efficient Guy's *Dental Practice seeks assistant to help satisfy* demand for treatment by appreciative patients. Five-day week—no evenings. 'Phone Welbeck 9433 or write Box No. 179/1.

BIRTH

MORRIS.—On August 19th to Barbara (née Freeman) and Dr. George Morris, of 169, Cranley Gardens, London, N.10, a daughter, Jane.

MARRIAGE

WALSTER—HARPER.—On August 20th, 1966, at Banbury, 2nd Officer David James Walster, M.N., to Dorothy May Harper, S.R.N., S.C.M.

DEATHS

BRUCE.—Mrs. Ian Bruce, née Patricia Mary Connolly, killed in the Ljubljana air crash on 1.9.66. Nurse Connolly trained at Guy's Hospital from 13.7.60 until 29.8.64.

JAMES.—On 26th August, 1966, in a flying accident, Dr. William L. James, O.B.E., and Lady Ursula James, of Domaine de Maitland, Mont-au-Prêtre, Jersey, C.J.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS
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* *Prog. in Biochem Pharmacol 1966 (In press)*

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PASSIM

New Guy's Men

This issue coincides with the beginning of the new academic year, and the Editors of the *Gazette* would like to extend a sincere welcome to all those who are coming into the Guy's community for the first time.

Entering, as they are, a huge University and one of Britain's premier teaching hospitals, we can promise them opportunities in abundance for enriching and extending their experience. They will soon discover, if they have not done so already, that everyone, due maybe to some perverted parental instinct, has a sneaking desire to pontificate to younger people on how best to spend time that they themselves have squandered. We shall resist this temptation but, instead, list those activities that are currently advertised as being a part of the Guy's scene and like Michelin, give each a star rating which we hope reflects their recent success in terms of student following. We might mention before we do this, however, that those with few stars should not be ignored but exist as a challenge for the new students to revive them—plagiarizing the late President Kennedy, "Think not what Guy's can do for you, but what you can do for Guy's."

Archery Club? Art Society ★★★. Association Football Club ★★★★. Athletic Club ★★★★. Boat Club ★★★★. Boxing Club ★★★★. Bridge Club ★. Catholic Society ★★★. Chess Club ? Christian Union ★★★. Cricket Club ★★★★. Croquet Club ?? Debating Society ★★★. Dental Society ★★★★. Fencing Club ★★★. The *Gazette* ★★★. Golf Society ★★★. Hockey Club ★★★★. Jazz Society ? Lawn Tennis Club ★★★. Motoring Club ★★★. Mountaineering Club ★★★. Music Club ★★★★. Photographic Society ★★★. Physical Society ★★★★. Physiological Society ★★★★. Psychological Society ★★★★: Pulse ★★★. Quodlibet Society ? Rifle Club ★★★. Rugby Football Club ★★★★★. Sailing Club ★★★★. Squash Rackets Club ★★★. Students' Club ★★★. Student Education Committee ★★★★. Swimming Club ★★. Table Tennis Club ★★★. Theatre Club ★★★★★. Women's Golf Society ? Women's Hockey Club ★★★. Women's Lacrosse Club ★. Women's Lawn Tennis Club ★★. Women's Squash Rackets Club ★. Women's Swimming Club ★★.—There are also a host of others in the U.L.U. ★.—Failing all of these one can either work ★★, or FALL IN LOVE ★★★★★.

House Appointments

In the next issue we will be printing fuller details of the new plan for house jobs and a list of those jobs that will be available in December.

Who's afraid of the big bad truth?

Throughout its long history Passim has from time to time drawn the attention of its readers to various features of the life of the hospital that were considered to merit either praise or criticism. Being the personal viewpoint of the editors it has in the past received, not unnaturally, only mixed support and sometimes quite strong counter-criticism. The topic of this editorial, however, is so distasteful and its frank discussion so long overdue that it is to be hoped most firmly that some radical change will follow its publication. But in recognition of the privacy of its content it must also be hoped that none of the newspapers will see fit to report it.

For many years now there has been in the hospital a rather small but readily proselytizing group of students whose behaviour can only adequately be described as porcine. A full list of their past activities would be quite unpublishable not only because of its disgusting nature but also because it would merely provide the offenders themselves with a source of notoriety in which they would wallow.

Although it is perhaps true to say that nearly every college and university in the country has similar groups and despite the fact that there are a host of adequate psychological explanations for their existence, it is Guy's particular misfortune that here this band of destructive and aggresive juveniles has been permitted not merely to prevent normal student social life within the hospital but to actually typify it. Their crude amorality, coupled with a rank incapacity for holding alcohol, has now become a chronic and squalid feature of nearly every student gathering. The consequence of this situation has been that every intelligent and discerning newcomer has tended to automatically exclude the hospital from his social life, leaving this undesirable status quo to persist year after year.

No one would suggest that what is politely called "high spirits" wasn't an excellent release valve and that there wasn't perhaps something wrong with students who never let go once in a while, but what is being deprecated here goes far beyond the line which normal decent human beings should draw, let alone those intending to enter the professions.

However, perhaps the most saddening thing apart from the behaviour of this group has been the feebly permissive attitude of the majority of the students towards them. It would seem that now that yet another academic year is about to begin it is high time that there was a change in attitude by all concerned. The East Wing Union building, perhaps the finest of all the teaching hospitals in the country, has been scarcely used since its was opened, the weekly Hops being mainly patronised by outsiders. The opportunities are ready and waiting, all that is needed is more initiative and less cynicism. Then perhaps Guy's will begin to live up to its fine reputation.

News of Old Guy's Men

For some time we have felt that one of the reasons that prompt many of our readers to continue taking the *Gazette* is curiosity to find out what has happened to their colleagues whom they knew as students but have since lost contact with. In order to satisfy this curiosity more adequately, we are intending to commence this autumn a special section in the *Gazette* entitled "News of Old Guy's Men".

Quite obviously for this to prove practicable we will have to depend upon our readers writing in and telling us what they themselves have been up to since leaving and also passing on information about their friends. At this stage it would be rash for us to state exactly how we will be presenting this "News" as it will largely be decided by the quantity of information we receive. However, at the outset we would like to prevail upon our hoped-for correspondents to be brief but not modest and to state quite clearly the year of qualification of whoever they are writing about.

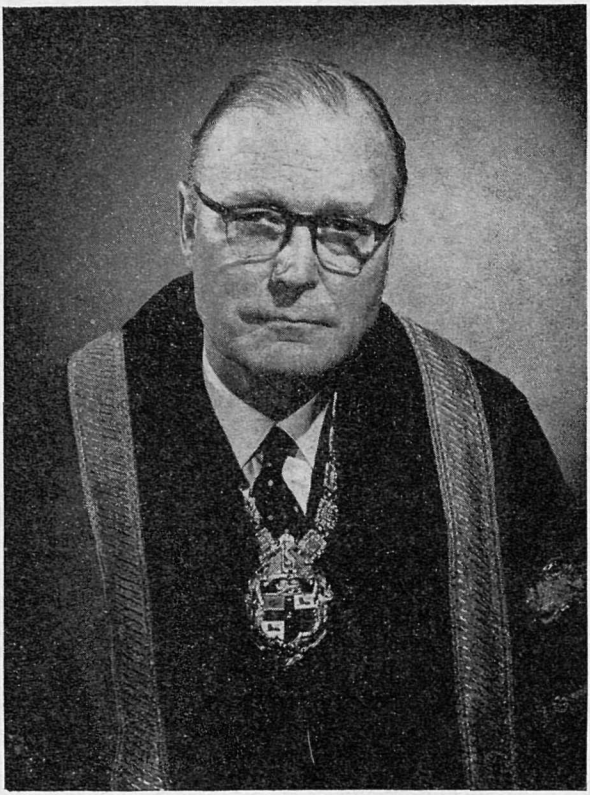
Our edition of August 20th included the first of a short series of articles concerned with Dental Education, with particular reference to the curriculum. The initial contribution by Dr. A. R. Ten Cate, Senior Lecturer in Anatomy in relation to Dentistry, featured many of his interesting concepts concerning the Pre-Clinical Course. In this issue, the series continues with a communication from Professor W. J. Tulley, Professor in Orthodontics, who has provided some provocative statements concerned with the clinical aspects of the syllabus. Two further articles will be printed, one by Mr. M. Wilton, expressing the student's viewpoint and finally some proposals by Mr. F. S. Warner, Dean of Dental Studies, regarding the proposed new curriculum.

Many newcomers, and indeed some who have already been here a while, find it a little difficult to know who's who amongst the Staff. So in this issue we are printing the photographs of Professor Atkins, on page 484, and the Matron on page 492. And in future *Gazettes* we will continue this practice as time and money allows.

GUY'S DIARY

SEPTEMBER			
30th	F.	8.30	p.m.—2.00 a.m., "Inflam No. 1", a party in the Students' bar.
OCTOBER			
3rd	M.	1.00	Mr. SALMON. Clinical lecture.
4th	T.	1.00	Dr. MANN. Clinical lecture. "Gall-stones".
13th	Th.	5.00	Neurosurgical Round in the Clinical Theatre, conducted by Mr. PETER SCHURR.
22nd	Sa.	10.00	Clinico Pathological Meeting, Clinical Theatre.

CONTEMPORARY PORTRAITS



Professor Hedley Atkins

The President of the Royal College of Surgeons

DENTAL EDUCATION THE CLINICAL PERIOD

by

Professor W. J. Tulley

The rebuilding of many schools with better facilities and increased numbers of students has been responsible for the present critical appraisal of the dental curriculum.

In the first of this series of articles, Dr. Ten Cate reviewed the teaching in the pre-clinical period and made certain comments on possible changes. In future articles the students' attitude to the curriculum will be discussed and also the school's policy towards proposed changes. The intention here is to discuss general principles rather than detail and to provoke a response.

Many writers on this subject have assumed that some reorganization is necessary. Walker et al (1965), in a section of their paper on "Dentistry in the United Kingdom, a survey of the present position and future trends", state:— "The present-day pattern of undergraduate dental education has evolved during the last fifty or sixty years from beginnings which were almost entirely of a practical nature, conveniently divided into the following subjects: dental mechanics; conservation; and extraction of teeth." They point out that:—"Subsequent evolution of dentistry included the development of further subjects of which orthodontics, periodontology, preventive dentistry, and oral medicine and pathology are examples. These subjects were added to, rather than integrated within, the curriculum and gave rise to an imbalanced and largely unco-ordinated syllabus." The author contends that the basic principles of these subjects have been part of the dental syllabus for at least thirty years and it is only the emergence of super specialization, encouraged by the example of American schools, that has given the wrong balance to the syllabus.

It is perhaps useful to consider the basic curriculum as comparable to the engine of a modern production motor car. The basic concept of the engine is sound and well tried but it has been changed by the addition of more carburettors and other modifications which have made the whole mechanism somewhat cumbersome. Any change in future planning of the syllabus must be in the nature of the multiple choke carburettor which has replaced additional carburettors to give greater efficiency. Some schools are adopting a streamlining of the dental syllabus comparable to changing the shape of the motor car rather than the basic structure of the engine to give a more pleasing superficial appearance rather than to make it very much more practicable.

In recent papers and correspondence concerning changes in dental training, there are two opposing schools of thought. On the one hand there is a statemet by Walker et al that:—"Whatever the technical developments of the future, dentistry will remain a human biological science which in itself will ensure the need for university education under conditions closely related to medicine and biology." On the other hand there are those that submit that dentistry should be basically a technological course, pointing out that in the early days, dentistry was learned by a preceptorship or apprenticeship to a skilled dentist and that the accent on the technological side should not detract from its appeal and that the type of person who is required is one who is first and foremost a good technician.

The author cannot see that there is really a great deal wrong with the present clinical training if one considers that the primary object of dental education is to produce good, practical general practitioners in the first instance. There should be, as Dr. Ten Cate pointed out, encouragement for those who have the wish to do so, to branch out into a scientific training before taking their dental qualification in order to fit them for scientific research work in various aspects of dental science. However, if the course is so designed to be of a very much more theoretical nature, as is the tendency in some schools, the student on qualifying, will need more experience before really being "let loose" on the public.

One of the most comprehensive surveys on dental education, past and present, has been carried out by Dr. K. J. Paynter (1964) in Canada, under the auspices of the Royal Commission of Health Services and this has included an appraisal of education in British dental schools. Those who lean towards a more academic approach to the clinical period may well agree with a statement quoted by Paynter and made by R. E. Doughty, from the Carnegie Institute of Technology, in a paper, "The development of a professional education". Discussing the training of engineers he said that the object was to train students to become engineers rather than train them to be engineers. The problem is that after five and a half years a dental student has to be a fully qualified dentist. There are some who will specialize in aspects of dental surgery where they are required to go on with postgraduate training but our main objective is to produce competent dental surgeons at the end of the normal training period and this is obviously quite possible. General agreement has been reached on the fact that the course should not be lengthened.

Two main problems must be discussed: first the problems involved in giving a better integrated course and secondly to reconcile the two opposing ideas concerning a university education versus the technological training.

There is no doubt that the planned changes in the curriculum, to be described in a future article, will do much to bring the students away from the departmental teaching and will give them an earlier insight into the relationship between the basic science studies and clinical work. Sufficient time must be available at the end of the course for the treatment of patients under general practice conditions. Experienced senior demonstrators are required to supervise and

co-ordinate the work which might otherwise be done in separate specialist departments.

The student's first introduction to clinical work is related to older patients, many of whom are edentulous. This would seem to be quite out of keeping with the modern trend of placing the emphasis on the prevention of dental disease. However, it has for many years been found to be the best form of initiation. Other schools have tried the experiment of introducing the student to children. Although this is a theoretically more idealistic approach, it does not work so well in practice. Children are quick to recognize lack of experience and act adversely.

It is in a department of dentistry for children that the student obtains a real appreciation of the total dental care of the individual in the present curriculum. There should be more training in dentistry for children, which after all is the whole foundation of the preventive aspect. At the present time only three months of the whole clinical period are devoted to this particular aspect of dentistry and it should receive at least double the attention which it gets at the present time. Time for this could be found by making some reduction in the number of simple repetitive mechanical procedures in adult conservation but insisting on a high standard and also removing much of the repetitive mechanical exercises required in the processing of various forms of prosthetic appliances.

Until quite recently, one serious deficiency in training has been lack of teaching concerning the pre-school child and the various problems of early dental lesions. Considerable progress is being made in this field and it is to be hoped that this aspect of the subject, including other aspects of public health dentistry, will find a place in the undergraduate curriculum. Very few dentists who were trained before the war are happy to treat the very small child. Many have an inherent fear of such children and feel that this is something apart from what they had been trained to do—that is—restore the mouths of adults where the ravages of dental disease had run rife. This accent on public health dentistry has come more with the education of the public and the possibility of free dental treatment for every child and it is this demand which must be met in increasing numbers as the need for advanced restorative work recedes with improved early dental care.

It should be possible to give students sufficient knowledge of orthodontics and periodontology, which are not really new specialties, and also sufficient grounding in preventive measures that they can perform a useful service without so much need for dental specialists.

The subjects mentioned above provide considerable interest when related to their basic science backgrounds and if well taught should tend to offset some of the dull periods of the syllabus without introducing a lot of irrelevancies.

Paynter examined this problem of specialization which is far more acute in Canada and the United States and states boldly, as follows:—"Far better services could be rendered to the general public

if many of what are now classed as specialties could be included in the curriculum as dentists with a wider training would have less need to refer patients to specialists."

We have found over the last twenty years, at Guy's, that increasing the teaching of orthodontics and children's dentistry has made a considerable difference to the type of patient referred for consultant's opinions and a basic understanding of the subject is well shown in the letter of referral.

The school of thought that leans more and more towards returning to a proper technological training comment that the standard of dentistry in this country has become tailored to what is included under the items of service in the General Health Service. Disparaging comments have been made concerning the quality of dentistry in Britain today. The author believes that the overall standard of dentistry, in relation to the community as a whole, is better in this day and age than in any other time in our history. Although there is no need for complacency, the practitioner leaving our dental schools has a much better grasp of the principles and specialized aspects of the subject than he did twenty or thirty years ago. It must be admitted that there are not quite so many dentists who can boast of always placing cohesive gold fillings or such other exacting techniques but there have never been many such technical perfectionists in the profession. We need not really fear a lowering of standards. If we look back it is obvious that so far tremendous progress has been made since the "Twenties", where there was such a sharply divided difference between the fashionable practitioner and the "blood and vulcanite" practice.

The author believes that the dental curriculum should be so designed that those students who wish to add to their skills those of advanced operative techniques required in the more advanced forms of conservative dentistry, should be allowed to develop this range of their activities to the full. All must have a certain standard of manipulative skill but it is true to say that a large body of the profession will be good, sound, general dental practitioners. A small group may find, in dentistry, an interesting branch of medicine and might, in a way, be described as dental physicians. If such flexibility is built into the curriculum, particularly in the last year of the clinical period, opposing schools of thought can be reconciled.

It is of the utmost importance that the profession is honest with itself. The need to glamourize a subject by making it more of a special university discipline may stem from some form of inferiority complex. There is no need to bolster the subject in this way because everyone appreciates the highly complex technical procedures which are required of the dental surgeon. He has at the same time to be able to manage patients of all kinds, and this should be a sufficiently satisfying entity in itself. A similar type of complex seems to be occurring in the medical profession with the great desire to specialize.

Again quoting from Walker et al:—"the graduate dental surgeon will be required to undertake more responsibility for diagnosis and treatment planning and advanced operative procedures if ancillary

personnel trained in routine dental care, particularly of children, hygienists and technicians take over other aspects of treatment."

Dental surgery has over-emphasized the use of the term "diagnosis" because apart from certain pathological lesions in the mouth, which are relatively rare, most of the problems involve either the carious process or acute and chronic inflammation of the periodontal tissues and also the degenerative changes with age. The one major breakthrough of this century has been the discovery that fluoridation can produce a change in mineralisation and the tooth surface can be effectively hardened. But we are still a long way from overcoming the carious process. It is towards this end that the men trained in sciences can be of the greatest advance to the profession. We must not overplay the role of preventive dentistry. The author believes that even if all local authorities were to institute fluoridation of water supplies, and the population was so educated to take care of its mouths by taking all the precautions advocated by the profession, there will still be a considerable amount of routine restoration of teeth required. This century will not see the end of dental disease. There will also be considerable need for treatment of gum disease and eventual prosthetic restorations with the increasing problems of longevity.

Because of the very nature of dental diseases the problems of inherited tendencies are not fully appreciated and perhaps too much stress has been placed on the environmental features. These problems are bringing an increasing interest in the public health aspect of dentistry which must receive some attention in the curriculum. The student will have to learn to work with the ancillaries, who are here to stay.

One of the most useful appointments which students hold at Guy's and which they do not have in many other schools, is in the Casualty Department. At this time of their training they see an honest cross-section of the dental ills of the community, which result largely from neglect, but also from trauma. In some schools the teaching is so organized that all their patients are prepared in advance for them and allocated in an orderly and administratively tidy way. Guy's is one of the few teaching hospitals that maintains a twenty-four hour service for such dental ills and by doing so, offers a proper service to the community. Dentistry cannot be looked upon as a nine to five profession if it is to be of real help to the community. Despite the preachings of the profession, people will never be able to carry out such meticulous care of their mouths that they will be able to control their own dental pain and various traumatic injuries which come about in so many ways.

One aspect of modern dentistry which is coming into favour is the use of intravenous anaesthesia to carry out long, elaborate dental procedures which otherwise may take several appointments. This is being done by many practitioners in this country and is, of course, very much appreciated by the more nervous patient. It brings with it certain hazards but it also emphasises the need for very good training in anaesthetic techniques. Whether such a form of treatment should be allowed to become widespread, with its attendant dangers

of the operator acting as his own anaesthetist is debatable, but certainly, in a modern teaching programme, the student must know something of these techniques and be able to, at least observe them.

In relation to this treatment of the unconscious patient, there is a highly organized form of surgery layout and nursing. The whole problem of equipment design and the ergonomics of dental procedures are under review to ease the strain of dental practice. The student must be able to see and possibly work with such equipment at some stage, which is going to date the old "Christmas Tree" dental surgery unit.

In conclusion, no drastic re-organization is necessary or practicable in the present clinical training but some form of integration of clinical and pre-clinical subjects and more emphasis on overall treatment planning is desirable. An increase in the amount of clinical time given to the treatment of children is indicated. There is a danger of introducing too much theory and diminishing the practical aspect of the subject to the point where the newly-qualified dentist is ill-equipped for general dental practice.

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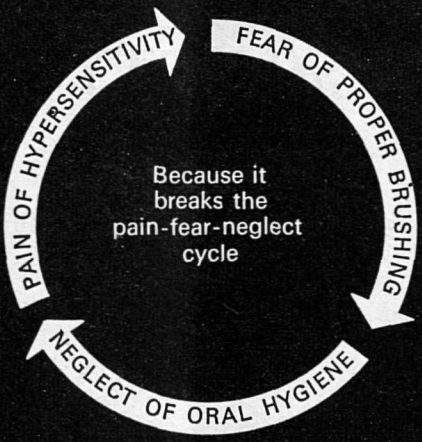
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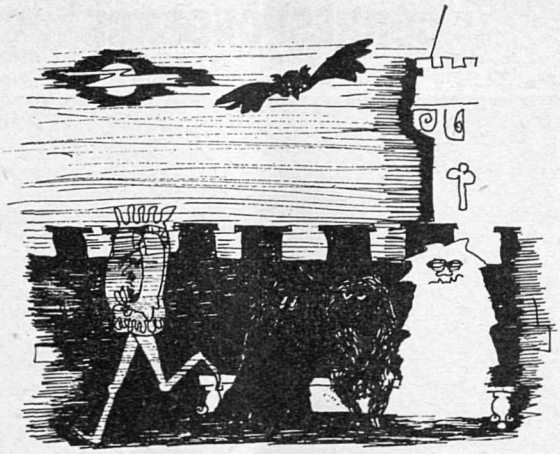

"HAVE YOU NOTICED HOW LITTLE REAL CLASS THERE IS AMONGST THE YOUNGSTERS OF TODAY?"

NOTICES

Christmas Concert

The Christmas Concert is being held this year in the Chapter House of Southwark Cathedral on December 7th and 9th.

Programme:—

Britten—Ceremony of Carols.

Handel—Two Coronation Anthems (Zadok the Priest; Let thy hand be strengthened).

Viraldi—Concerto for two trumpets.

Rehearsals have already begun (Tuesdays, 5.30 p.m. sharp). If you enjoy singing, come along!

Will all Secretaries please note the dates, so as to avoid a clash of activities.

MICHAEL COE (*Sec. Music Club*)

The Table Tennis Club
1966 Table Tennis Knock-out Competition
The K. E. Pringle Cup

The competition this year was a success in two ways. Firstly, it proved to be a good social occasion; and secondly, it brought forward potential team members for the coming season, such as D. Lindridge and P. R. Walker.

The winner this year was C. S. Ong. Ong was only narrowly beaten into second place last year by Nicholson, the previous winner. L. Dobson fought hard for second place, and D. Lindridge was placed third.

The Club would like to announce that the A.G.M. will be held in the Anatomy Theatre on Monday, 24th October, at 5.15 p.m.

"Freshers" trials will be held in the table tennis room of the East Wing on Monday, 17th October.

K. TAYLOR, *Hon. Sec., T.T.C.*

CORRESPONDENCE

THE MATRON

Staffing Impasse

SIR,—I am indeed indebted to you for reprinting in your last edition a summary of the interview which Miss Brysson Whyte and I gave recently to the Editor of the *Nursing Times*. This, coupled with Passim in that same edition, should do much to clarify the problems with which the Nursing Service has been grappling during these last two years, and which provoked your remarks in Passim of August 6th, 1966. In that edition, you anticipated that "Matron's Office" would comment in the following publication! As bricks and mortar have no power of pen or expression, there has been silence! May I now reply?

I would like to enlarge upon the report given in your edition of 17th September, concerning the meeting held by the Chairman of the Board of Governors with the Sisters. There is no question that Sisters other than those working in Hunts House are to be left as a part of the ward team. It is obvious that there can be no sudden answer to this situation—but let no one be in doubt that the correct use of trained nursing staff throughout the Hospital is under review. The Sisters of New Guy's House will not be left to continue under their present stress. It is essential, however, to have a full assessment of the time-table and management of all commitments of the Operating Theatre Suite—and also of the Intensive Care Unit—before the complexities of the surgical wards can be seen in their true setting.

Other areas of the Hospital are very likely to require a radical reorganization which will call for a realistic approach by the many concerned with the maintenance of their function. When this has been accomplished in full, it will thereafter be imperative for every new undertaking and expansion of work to be meticulously assessed in all its requirements—from Consultants to pillow cases—from Nursing Service to portering; and from Chaplaincy to furniture, such as beds and their use.

People who attended the Nurses' Prizegiving of 1963 will remember that I stated categorically that no student nurse training school could expect to flourish in the future unless the Hospital also provided adequate training programmes for Post-Registered students. At that time, I expressed hope that five new Courses might be prepared and implemented. I trust that we may shortly proceed with some of these—but—an increase in the tutorial staff will be imperative—the support of lecturers essential—and accommodation vital, if these needs are to be met. Courses must be of genuinely substantial value, or the possibility of obtaining people under false pretences raises its ugly head. At present, Guy's has just three Post-Registered Courses—for Midwifery, Mental Nursing and Paediatrics. We need to widen this field considerably.

Ward Receptionists—one between each pair of wards in both New Guy's House and in Hunts House—will shortly be in post. A scheme of voluntary helpers under the guidance of a full-time organizer has been approved. These plans will do much to relieve pressures on the over-taxed Sisters. In my opinion, the nursing profession throughout this country has tried too hard, for too long, to fill too many gaps in other services. The Board of Governors have now agreed in principle that we may be able to increase our part-time staff by establishing a nursery school or crèche. I hope that it may be possible to report further on this project in a later edition of the *Gazette*. Similarly, there will be reports published concerning the implementation of the new services to be provided, the expansion and development of nursing auxiliaries—and other projects. I trust that the *Gazette* will allow us adequate space in its columns for these purposes!

I believe that this recent *impasse* at Guy's is truly a blessing in disguise: the disguise may be uncomfortable for some and unacceptable to others, but a climax of events which requires the community to take stock of itself, its organization—and its *communications*—must surely be welcomed. There is no doubt that many hospitals up and down the country are watching Guy's with both encouragement and interest.

Mr. Editor, I thank you for your encouragement to the nursing administrative staff. I am glad to be able to remind you that the Board of Governors has recently agreed to the new appointment of an Assistant Matron to be totally involved in new projects, research and future plans. This will mean that for the first time for eighteen months one of the Assistant Matrons will be returning full-time to the nursing administration, instead of spending two whole days a week on Tower Block Planning. We shall have a reshuffle of our particular commitments, and all of us greatly look forward to increased mobility, and less diabolical desk-bound concentration. It has become virtually impossible under the present arrangements to manage adequately the vast amount of present day-to-day pressure: the maintenance of invaluable and well established contacts of yesterday: the planning of all the activities of tomorrow: and the vital need for keeping close personal contact with the units and departments of the Hospital, the training school, and the wards.

If we are to achieve the work we want and need to do, we must hope for still *greater* co-operation and support from the few who sigh for the habits of ten to fifteen years ago. The world can never turn back—and Mr. Editor, I beg of you, believe if you wish that we are half blue and half deep vermilion, but NOT "slightly pink"! There is no room for anything so insipid, nor will it *ever* be found in the nursing administrators of Guy's!

Yours, etc.,

ANNE M. JOHNSON, *Matron*

Matron's House,
Guy's Hospital,
London, S.E.1.

Dental Education

SIR,—I should like to congratulate Dr. A. R. Ten Cate on his article published in your issue of August 20th, concerned with the pre-clinical aspects of Dental Education. His proposals describe a logical sequence of events more likely to allow a greater degree of flexibility and, if adopted, would assist students in recognizing their capabilities and planning their future career.

With regard to Tooth Morphology, it is possible to make out a sensible case for the deletion of the subject at this early stage in the curriculum. However, it seems equally wise to make a plea for the retention of the subject, even though the work involved is carried out in conjunction with the pre-clinical course in Operative Dental Surgery.

Critics of the present arrangement may feel that the time spent on tooth carving is excessive when compared with the benefits gained from the procedure. Nevertheless, the benefits of practical procedures of this type are not entirely direct, for indirectly, a great deal of useful information can be acquired in relation to the students attitude to the work involved, and some insight of this nature often proves more useful than purely recording examination performances. It is interesting to learn that some students express a considerable degree of interest in the desirability of early assessment of the practical aptitude.

Those students who seem the most academically minded, sometimes experience noticeable difficulty initially, but by understanding the aims and objects of the Tooth Morphology course and applying themselves deligently, they eventually reach a satisfactory standard. Another obvious group with an inherant degree of manual dexterity are able to produce the required standard easily and effectively and often appear to be destined to be successful in the performance of practical dental procedures. The main body of students between those two easily identifiable sections comprise those who, on the one hand are undoubtedly interested, but find that constant repetition is required to gain the desired result, whilst on the other hand there are those who appear uninterested, having neither the desire or the interest to succeed.

Although each case must be given individual consideration, broad divisions such as those suggested in this way, may give a fair indication of students future progress throughout the dental course and after qualification. Our responsibilities in addition to those to the community, on whom our graduates will practice, surely include recognition of such types of student and effective action in advising and guiding those who present themselves for a period of dental education at this School?

Yours, etc.,

D. LONDON

Dental Department,
Guy's Hospital,
London Bridge, S.E.1.

A doctor's place is in a wide field

SIR,—It is interesting to read Mr. Shearan's letter in your issue of September 17th. I see what he is saying, and up to a point I would agree.

However, if he is saying "A doctor's place is in the home" in some narrow stage I must part company with him.

I believe members of a scientific and humane profession need to embrace as wide a field as is possible.

I was fortunate, perhaps, to be an old man when I went to Guy's to look at those who were reading in the medical and dental schools. The people I met taught me more, perhaps, than I was capable of gleaning from text books. I was fortunate to meet those in the academic world and many who were not. In my case I tried to get a little of the academic view to put with the fairly wide experience picked up in the highways and byways. Believe me, Sir, it was an interesting experience and a difficult problem to one who had moved in war and peace. The more I live the more grateful I am to those who made it possible.

Yours, etc.,

JOHN C. DOMINICK

Treniffle Lodge,
Lawhitton, Nr. Launceston,
Cornwall.

The Cricket Club does give cause for concern

SIR,—In his letter to the *Gazette* of the 3rd of September, Peter Swift was worried about our Cricket Club, in the context of what may broadly be referred to as good sportsmanship.

We, amongst many, share his concern, and though the *Gazette* may not be the ideal forum for this sort of discussion, we cannot agree with the more recent letter that matters should not be aired in your pages.

As officials of other clubs, we had bitter contacts with senior members of the Cricket Club last term. The occasions of these contacts were in the East Wing, when most of the 1st XI arrived there for Saturday dances, already considerably worse for drink.

On the second occasion, patients as far away as New Guy's House, were disturbed by their passage through the Colonnade and complaints were received on this account. Not content, then, with trying to force entry to the dance floor, one very senior member was, without provocation, unforgiveably rude to a first year official of the Students' Club, and had to be restrained from striking him.

Despite approaches to the Cricket Club in the following weeks, no apology was ever received. If this is part of the pattern of " . . . intolerance held dear to the Cricket Club hierarchy" then we feel that we must follow Mr. Swift in writing to the *Gazette*.

Change, we believe, can only come from within a club and we hope that it will not, too long, be delayed. Thus, wishing to be constructive as well as critical, we are working on concrete rules of conduct for clubs at Saturday dances, to regulate who shall be admitted, and how.

We are, yours, etc.,

J. P. JAGO,
J. H. WILLIAMS,
T. KIRK,
Students' Club.

P. J. BURTON,
MARTIN C. MACE,
Boat Club.

South Africa

(*The following will be the last letters that we shall publish on the South African controversy.*—EDS.)

From where can the truth be seen best?

SIR,—With reference to the recent correspondence in your columns about conditions in the Republic of South Africa, I would like to remind readers of the *Gazette* about a recent incident which is of special interest to members of the Medical Profession.

The South African Medical Journal of 14th August, 1965, contained a letter from Dr. J. G. K. Dean, F.R.C.P., consultant physician to the Provincial Hospital Port Elizabeth, stating that in the course of his professional duties he had come across a number of cases of men who had suffered severe injuries, sometimes fatal, apparently due to assaults on them which had occurred while they were being held in local gaols or police stations. Dr. Dean went on to state that it was the professional duty of doctors to make public any such information which they encountered in the course of their work.

Dr. Dean was arrested, and appeared in court on 13th December, 1965, charged with publishing false information about conditions in prisons, a charge which can carry a ten year prison sentence. However, before Dr. Dean's next appearance in court, letters appeared in a number of Journals, such as *The Times* and the *B.M.J.*, written by physicians, such as Drs. Doll and Fletcher, and Drs. Church and Brody, all testifying to the scientific competence and personal integrity of their friend and colleague, Dr. Dean. On 3rd February, 1966, the charge against Dr. Dean was dropped: the Prosecutor gave no reason for this, but it is not unreasonable to suppose that the South African Government shrank

from attempting to answer the serious and highly embarrassing allegations of an internationally known medical research worker in the glare of what was by then considerable world-wide publicity, and it is also not unreasonable to suppose that a less well-known doctor would not be so fortunate.

This case illustrates how political pressures of a kind wholly unknown in Great Britain can make life unpleasant in the Republic of South Africa: not just for "Communists" or "Politicals", but quite possibly for any member of the medical profession who is merely carrying out his ethical duty of protecting his patient's interests. It also draws attention to a more general point, namely the determined way in which the South African Government is trying to conceal the facts from its own citizens. For example, the Minister of Justice has powers of detention that are so wide that the Minister can effectively detain anyone that he thinks fit, and he need give no reason for doing so. The detention is for a ninety day period, but this can be renewed indefinitely at the discretion of the Minister. Furthermore, it is a criminal offence merely to state that any person has in fact been detained, and so citizens of the republic cannot possibly know who has been detained, and why. Again, as the case of Dr. Dean illustrates, the South African Government acts with particular harshness against anyone who draws attention to conditions of detention or imprisonment, so that allegations by responsible men, which would give rise to serious misgivings in any democratic country, are regarded as grounds for criminal prosecution. It is as a result of this State-enforced ignorance that Dr. D. P. Davis can state, quite falsely, that detention only applies to Communists, and merely involves confinement to one's home. In these circumstances it is perfectly possible for observers in London to have a more accurate picture of what is going on than people in South Africa itself, and to criticize accordingly.

Yours, etc.,

J. H. STEADMAN

32, Godfrey Street,
London, S.W.3.

The Respect due to human dignity

SIR,—I have been following the controversy triggered off by Dr. David Stafford-Clark's letters and suspect that some of the correspondents may be confusing fact with fantasy, a process that can be innocent but is more often malignant.

Dr. Stafford-Clark has posed a few elementary questions regarding human dignity and the respect to which it is entitled. These questions are too important to a process of degradation by another. The evidence for this grows steadily and

It appears that in South Africa one set of human beings is being subjected to a process of degradation by another. The evidence for this grows steadily and the whole has too many parallels in recent history to make it readily acceptable even for many of its supporters, whilst its opponents, even those of a mildly liberal sort, are left only with feelings of sickness and despair.

To let this pass without comment is akin to condoning any crime against humanity whether it be committed in Africa, China, The Americas, Russia or wherever.

Surely an institution such as Guy's, with its reputation for fearless enquiry and self-criticism, can permit the free discussion of a topic which has such a vital relevance to the human condition?

Yours, etc.,

J. H. WILLIS

Stone House,
Near Dartford, Kent.

South Africa Defended

SIR,—I was very sorry to see that South African politics has entered in our *Gazette*.

I personally hold no brief for the Nationalists—I am still a staunch United Party supporter—but must defend the present government in so much that their own people are accusing them of doing too much for the Bantu and the Coloured, and not enough for the under-privileged white.

In last Wednesday's paper it was reported that the reason given by the man who assassinated Dr. Verwoerd was that this government was doing too much for the Bantu, and not enough for the whites.

I would like to extend a very cordial invitation to Dr. D. Stafford-Clark to come and stay with me, so that he can see for himself what is happening, and to bring Tom Lewis along for good measure.

Yours, etc.,

L. N. THERON (Guy's, 1922)

P.O. Box 78,
Graaff Reinet, S.A.

But What is a Subversive Element?

SIR,—I feel the editors of the *Gazette* are to be congratulated on printing Dr. Stafford-Clark's original letter, for no other correspondence has aroused such interest since the inception of the National Health Service. For medical men to air their opinions on this subject is surely healthy for the suppression of a neurosis would be more harmful.

As the truth will not be arrived at in your columns, this correspondence must obviously terminate soon. Letters on both sides are so full of falacious arguments (astounding to think that these men passed 2nd M.B.!) and quite obviously have no intention of conceding points made by their opponents.

For instance, how can a man who is denied the vote protest against his government except by becoming "a subversive element"? It seems to be easily forgotten that South Africa's prosperity is due not only to its rather fortunate natural resources but in some measure to the abundance of cheap black labour.

One hopes that the editors policy will continue and that further controversial subjects may be stirred up in your columns. There seemed to be a possibility from vague rumblings in the cricket club, but one rather suspects this may be sniping by the slow bowler of a losing side, whose captain hasn't risked putting him on!

Yours, etc.,

R. G. CUMMING, L.D.S., R.C.S. (Eng.)

Gloucester House,
8, Gloucester Street,
Faringdon, Berks.

The Appropriate Final Word

SIR,—You will doubtless be concluding this correspondence fairly soon, and in light of some of the letters you have published I would welcome the opportunity to make some brief observations among the last batch of letters which you publish on the subject.

Most of the letters are self evident in their mertis or demerits and I intend to refer only to four of them: the first is Dr. Leeming's. If he had included in his homily about the virtues of a Guy's training, and their implications, the very reasonable observation that it is rash to rely upon anecdotal evidence, he might not have concluded his letter with two such egregious examples of his own gullibility about the supposed gullibility of British public opinion. Contrary to his and many other correspondents' belief, anyone in Britain can study very fully all sides of the South African problem, as expressed by their various protagonists. This is what I have done, and I have read the writings and speeches of the late Dr. Verwoerd, of Mr. Worster and a number of official publications of the South African Government, as well as the books to which I referred in my letter published on August 6th.

Dr. Paine's earnest request that politics should be kept out of the *Gazette* reads oddly in the context of his proclamation of himself as a refugee from British Socialism. I have written a personal reply to Mr. Pedley's courteous letter. All I will say here is that his final plea for more tolerance and better understanding is unexceptionable, but has also been for many years the unanswered plea of the majority of his fellow countrymen to a Government which entirely rejects such gestures. Dr. Cresswell supposes he must have misunderstood me on one point: he is right, he did misunderstand me. The object of my original letter was not to discourage a potential emigrant, but simply to indicate that he would need to know where he stood on matters which deeply affect the lives of millions of human beings—as well as the disputed promise of their future.

What remains unfortunately true is that although the facts are available and terrible, not one of the correspondents who attacked my views has attempted seriously to refute them. The reason is that the facts are irrefutable whatever the views expressed, and no matter how sedulously those facts are bypassed or ignored.

Yours, etc.,

DAVID STAFFORD-CLARK

York Clinic,
Guy's Hospital,
London, S.E.1.

[*This correspondence is now at an end.*—Ed.]

REVIEWS

BASIC HUMAN EMBRYOLOGY.

by P. L. Williams, C. P. Wendell-Smith and Sylvia Treadgold. London: Pitman Medical Publishing Co., Ltd., pp. 136. *Price* 25*s*.

This is quite a remarkable book. In the short space of only 136 pages, nearly half of which contain diagrams, the authors have managed to give an up-to-date account of human embryology. They have not been content to adhere to only what is traditionally included under the title of embryology but they have moved both backwards and forwards, backwards towards a clear summary of protein structure and the control of gene action and forwards towards some consideration of postnatal growth and motor development during the first year of life.

There may be some argument as to how much embryology a medical student ought to be taught but this book indicates that the subject has a definite and important place in our understanding of many aspects of the structure and function of the human body. At times there is too much detail, or rather in an attempt to get too much into a small space, sentences become overloaded with too many facts. On the other hand there is always a well drawn, clearly labelled diagram to help the reader's understanding and make revision rapid and easy.

One could call this a "Guy's" book, but it is not for that reason that one wholeheartedly and without reservation recommends it to the students. Some embryology ought to be known and this is the best textbook available at the moment.

J. JOSEPH

A SYNOPSIS OF OBSTETRICS AND GYNAECOLOGY.

A. W. Bourne and J. M. Holmes. 13th Edition. J. Wright & Sons. pp. 688. *Price* 52*s.* 6*d.*

The main advantage of this book is that it is easy to look up any subject and find the information in note form and under clear headings. It has also 167 small diagrams in black and white. The book attempts to cover the whole field of Obstetrics and Gynaecology, but some subjects are dealt with in too great a detail and others rather shortly for the size of the work; for instance, the operative management of Prolapse only occupies half a page, and the sections on Malpresentations, Multiple Pregnancy and the "Grand Multipara" are short. Although the book has been produced in a new edition, some of the sections on treatment seem to have been forgotten in the revision, for there is frequent mention of the use of Bromides. For Nervous symptoms and Insomnia at the Menopause "Bromides, hyoscyamus and belladonna" are recommended.

The book cannot be recommended as a reading textbook for Obstetrics or Gynaecology, but may be of use to the student for revision purposes.

C.D.E.

OBSTETRICS AND GYNAECOLOGY,

II Edition. By Christopher J. Dewhurst. pp. 230. Baillière, Tindall and Cassell. *Price* 21*s. net.*

This small hard-back book has been very carefully thought out and is eminently easy to read. Its few, well-chosen and useful diagrams blend well with a dogmatic text that is addressed in a personal style to the reader, reminiscent of Jeffcoate's excellent book on Gynaecology.

The chapters are short and achieve their emphasis by discussing the most important things first, often with quaint headings such as *"This section is vitally important: you must know it."* The division of space is as one would expect, 146 pages being devoted to Obstetrics and 72 pages on Gynaecology.

All in all it seems a successful endeavour, although its price at twenty-one shillings is perhaps little excessive, and one wonders why it was not brought out more cheaply in a paper-back.

M.D.

"MODERN HEALTH."

Authors: H. S. Gear, M.D., D.P.H., D.T.M., H. B.Sc., P. J. Cunningham, B.A., S.R.N., S.C.M., H.V. Cert. Publisher: Faber and Faber Ltd. Pp. 241. *Price* 21 *shillings.*

"Modern Health" provides a broad, international concept of preventive medicine and health. Widely ranging aspects of the subject are set out clearly and simply in eighteen chapters with few omissions, one a definition of health and one obvious mistake or misprint. It is concise, perhaps to the point of being responsible for a certain amount of tantalising brevity.

By reading chapter seventeen first on "Health Services and their Organisation", students may more readily understand and place in perspective the great amount of information in the remainder of the book.

In "Environmental Health" the elementary services and facilities for "health, self-respect, self-realisation, with provisions of the services, not necessarily satisfying all the desires or even the essentials of man and his family with their social privileges and responsibilities, needs for recreation and social life, with the means to enjoy natural beauty and avoid ugliness", are very well stressed. Ideal housing needs are also clearly defined.

" Mental and Physical Health Associated with Environment " fails to consider trends in this country on the increasing and important issues of the problems concerning moving or changing populations due to large scale residential or industrial development or assimilation of immigrant groups or loss of critically required skilled groups in emigration. Also, the progressively increasing screening tests for such diseases as diabetes, venereal disease, cancer, etc., offered to various vulnerable age groups, surely deserve more consideration.

Readers are reminded that a child's nature is influenced by his forbears, his embryonic existence within the uterus and his process of birth. Brief mention is made of some abnormalities in childhood, but it surely would have been much more valuable to provide a basic explanation of the variations of the normal in modern assessment techniques first.

In the section on " The Health Aspects of some Chronic Diseases", the disabling, rather than killing conditions, the necessity for more research with improved communications between medicine and sociology are rightly emphasised, too.

The appendices with death statistic charts from the early eighteenth century to 1963, examples of some local authority expenditure for some vital services and the usual vital statistics are provided in such a manner as to make stimulating and interesting reading. The book is completed by an index appropriate to its size. Pp. 241.

It will be essential reading for all student nurses to whom it ought to be readily available. Interested students and those required to gain a closer knowledge of aspects of modern health will also find it very valuable, as will those contemplating practising abroad, especially in the developing countries.

G. SAINT.

ANAESTHESIA, RESUSCITATION AND INTENSIVE CARE,

by Norris and Cambell. Published by Livingstone, 1st Edition. *Price* 30*s.*

This book excellently illustrates the present scope and expanded frontiers of anaesthesia and so should be very helpful to those tentatively thinking of entering this speciality. It is, however, primarily aimed at students, and the newly-qualified, and succeeds in giving very practical advice on basic anaesthesia and resuscitation without getting involved in rather muddling discussions on technique. In spite of this it is much more than a vade mecum of anaesthesia, and the contents are supported by clear physiological and pharmacological principles.

A Houseman, having responsibilities in the Intensive Care Ward, will find a great deal of useful information in the chapters devoted to intensive care and resuscitation.

The place for regional and epidural anaesthesia is adequately considered. It is hard to fault this book.

D.R.W.

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NURSING SECTION

Democracy and Co-operation

A cold blast of air is blowing through the old and comfortable habits which still administer in the nursing world. New ideas and methods are being accepted by younger and more progressive members of the profession. The only way to take part in and keep abreast of current events is to forget the old ideas which have done duty for so long. It may be sacrosanct to consider changes in basic administration, but modifications there must be in order to produce an efficient and clear-thinking organization. It appears that all preconceived notions must fall by the way and changes accepted with an open mind. This is naturally difficult to achieve when one has been working in the same profession for any length of time.

Ward routine has changed and the patients' day has changed. It has proved psychologically and physically better to nurse patients in conditions similar to their own home lives. In hospital, patients are now getting dressed during the day; they are going out on week-end leaves; their hospital-stays are on the whole shorter, and many hospitals are now using five-day wards. In the light of these advancements the medical and nursing professions are now gearing themselves to new methods of treatment.

Democracy is now the approved method of leading those who are still in training. The officer in charge of the ward is no longer the autocratic leader she was 10 years ago. She is working alongside her nurses. Due to training changes the younger and less experienced members of the profession are being left in charge of affairs. Many of the old school feel that they must stay to supervise them. This must be all wrong. One can only learn by experience and it is surprising how well the young nurses manage.

There has been much comment in the National Press on shorter hours and better working conditions, with corresponding increases in payment for both nurses and doctors. Concerning the question of hours, the nurses are ahead of the doctors in their attainment of a shorter working week. There is no necessity for any person to be "on call" for 24 hours of a day and seven days a week. Just because our predecessors did it there is nothing to be gained by their saying "hard work never did anyone any harm", and "if we could do it so must they". The average reply by any young doctor or nurse must be, "we will change this". However, they are constantly finding that they are hitting their heads against a brick wall. The only solution appears to be to get out of an outdated method of work. The harm being done to the professions by those who will not allow change is soon going to be irreversible.

Nurses appear so intolerant of change. Even the uniforms we wear are unchanged from those that were worn by our colleagues of 50 years back. Hems may rise but the general style remains the same. The more starch and frills in the uniform the more the majority of nurses are attached to it.

Progression must advance steadily and tolerance and trust between both older and younger members of the profession is the oil that the smooth wheels of change must run on.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

S/N J. N. Caswell (née Sirett) S.R.N., to the Introductory Course, School of Nursing.
S/N M. Cracknell, S.R.N., to Main Theatres.
S/N C. M. Davies, S.R.N., to Bright Ward.
S/N J. Farnan, S.R.N., to Diplock Ward (part-time).
S/N A. Head, S.R.N., to Nuffield A Floor.
S/N J. Mitchell, S.R.N., to Sarah Ward (part-time).
S/M M. A. Oloko, S.R.N., S.C.M. to Victoria Ward.
S/N E. O. Robertson, S.R.N., to Main Theatres (part-time).
S/N H. M. Ward, S.R.N., to the School of Nursing.
S/M A. Williams, S.R.N., S.C.M., to Victoria.

PROMOTIONS

S/N G. R. Elliott, S.R.N., R.S.C.N., to Ward Sister at the Evelina Hospital.
S/N M. M. Irvine, R.G.N., S.C.M., O.N.D., to Sister Night Duty, New Guy's House.
C/N J. Morrison, S.R.N., O.N.D., to Sister Esther Ward.

DEPARTURES

Sister C. Taylor, from Esther Ward.
S/N E. A. Jones, from Stephen Ward.

SPORT

RUGBY FOOTBALL

With the Indian summer continuing, grounds have been very firm and conditions perfect for throwing the ball about. However, Guy's were well held by a strong Blackheath side at the Rectory Field, who ran out winners by 8 points to nil. Changes were made following this match, in which Dr. Buny, who is being such an inspiration to the team this season, made his debut. Osbourne, plagued by injuries in the past, came into the centre for the game against Old Askeans and brought speed and decisiveness to the backs which will be necessary to give Guy's fast wingers, Ross and Morgan, the extra yard in which to move. Guy's at least beat the Old Askeans by 9—3 in a not very inspiring match.

Guy's sent a seven down to the Cheltenham tournament on September 18th. Unfortunately, the seven was not the strongest possible and they came up against Harlequins in the first round. The latter won 25—0 and went on to the final, only to be defeated by Moseley.

As people may or may not know, Guy's have lost some of their stronger fixtures over the last few years. There are several reasons for this: firstly, Hospital Rugby is not as strong as it used to be, and the stronger clubs prefer to play the top-class clubs—this is reasonable enough. Secondly, however, is the question of gate money. Rugby clubs need money to maintain standards, and one of the most important sources is from the collection at the gate. The big clubs come, or came, to Guy's and play in front of a mere handful of spectators, and hence their share of the gate, as well as Guy's share, was virtually nothing and hence the desire to play Guy's was diminished. This present trend is bound to continue if the gates at H.O.P. are virtually nil. At this time of the season, several people come to watch when the weather is fine, but when the wet and cold weather comes, gates fall off. To confirm this drop in the number of spectators one can find that the cash taken last season at H.O.P. for entrance and programmes was only one-tenth of that taken in 1950.

All clubs require support and everyone at Guy's not actually playing can afford to support the Hospital on a Saturday afternoon. Guy's have a good side this season and more support would be greatly appreciated.

To finish on a happier note, however, we must mention Guy's splendid effort in the Streatham sevens last Sunday, when they lost only 14—11 in the semi-final to Oxford Thursday, the winners last year, and eventual winners this year. In earlier rounds, Guy's had beaten Northampton, 15—5, who reached the Twickenham final in April, and Esher, 14—5. A marvellous performance!

HOCKEY

The Hockey Club have continued training hard and have played one match against Purley and had a trial with the London Hospital. Guy's had a much weakened side against Purley and lost 5—0. A full summary of the season's prospects appears below.

GOLF

The University of London Golf Club trials take place at Sandy Lodge Golf Club on October 5th, commencing at 10.30 a.m. Peter Ellis, of Guy's, is this year's captain and any inquiries should be made to him.

The Sundridge Park Club have decided to allow only twenty Guy's players to play in future, ten as full members and ten as 5-day members. The full members will pay £3 3s. 0d. towards their annual subscription, the rest £1 1s. 0d.

The list of Guy's players will be revised on October 1st annually.

SPORTS DIARY

RUGBY UNION.

October:

Sat., 1st—U.S. Portsmouth. Home. 3.0 p.m.
Sat., 8th—Cambridge University. Away. 2.45 p.m.

HOCKEY.

October:

Wed., 5th—Fresher's Trial, H.O.P.
Sat., 8th—South Saxons. Home.
Wed., 12th—Freshers Trial, H.O.P.

GOLF:

October 5th—University of London Golf Club Trials, Sandy Lodge G.C., 10.30 a.m.

REPORTS AND RESULTS

RUGBY FOOTBALL

GUY'S v. BROMLEY

At H.O.P. 9th September, 1966

Result: Guy's won 36—3

Guy's won this, their first game of the season, with great ease. The forwards dominated the Bromley pack throughout the game; and had good use been made of this possession of the ball in the first half, the score would have been even greater.

The first score of the game came after 15 minutes of indecisive play when Elliott put over a penalty from 35 yards. Bromley's first venture into the Guy's half was rewarded by the equaliser when their kicker landed a fine penalty goal from 40 yards out. Several attacking moves by Guy's backs during this period failed because of poor passing and poor backing-up. Morgan, on two occasions, overran Beacham's pass when otherwise he would surely have scored. Guy's finally scored when Ross beat three men to cross the line to round off a succession of movements back and fro across the field.

The Guy's front row were always in command of the set-scrums—Hey taking eight against the head. The long throws-in at the line-out were not successful, but Kingdon and Neville jumped well at the front of the line. The back-row, with Curzon especially prominent, were quickly on to the loose ball throughout. But despite all this the score at half-time was only 6—3; 30 minutes had passed before either winger saw the ball.

Within minutes of the kick-off, Davies—following up a kick-ahead by Beacham—made fully two yards before scoring under the posts. After ten minutes a defensive mix-up let Beacham through under the posts. In the next 15 minutes Sharp and Hey scored a try apiece by following up quickly and touching down under the full-back's nose.

Bromley now nearly scored after a mid-field mix-up by the Guy's backs, but Thorburn just cleared the line. Minutes later, however, he injured his ankle severely and had to leave the field. We all hope that this will not keep him out of the game for long.

In the last 15 minutes Guy's scored four tries—one by Morgan, and three by Ross. All were scored after good running, and the last—involving Sharp, Curzon and Elliott as well as Ross—was the best of the game.

The goal-kicking was awry; only four out of twelve attempts were successful.

It is a pity that on such a fine day at Honor Oak Park Guy's supporters were outnumbered by the Bromley supporters. It is to be hoped that many more people will support the team in this early part of the season when they play some of the hardest fixtures.

Guy's: D. R. Elliott; J. R. M. Ross, D. G. Lewis, R. J. Beacham, I. J. Morgan; B. J. Rowlands, P. G. F. Swift; J. E Davies, G. B. Hey, C. E. C. Lewis, A. J. Kingdon, C. G. Neville, D. A. Curzon, C. W. Thorburn (Capt.), H. C. Sharp.

J. H. W. DAVIES

HOCKEY

PROSPECTS FOR THE COMING SEASON

Although official fixtures do not start until Saturday, October 8th, when South Saxons are our visitors, three pre-term fixtures have been arranged. These include mid-week games against Purley and Habari, and a friendly with the London Hospital. The Freshers' trial will take place on Wednesday, October 5th.

The hard work done by Fixture Secretaries in the past three years to improve our fixture list is now taking effect. New fixtures this year include Teddington, Surbiton, Gore Court, and Wimbledon. As many of our fixtures now comprise block fixtures of four XI's against the same club, it is essential that we turn out four regular teams to maintain these fixtures. Unfortunately, the club still only have the one ground at H.O.P., though Peek Frean's have again very kindly offered us the use of their pitch at Sidcup on a number of occasions throughout the season. However, this does not hide the fact that we need another regular pitch every Saturday if we are to retain these better fixtures.

Last season was not particularly successful, though the Second XI did share the Junior Cup, drawing with St. Thomas's in the final. The Second XI have either won or shared this Cup for the past three years—a fine record—but it is that long since the First XI reached the final. Although the team will probably be young and inexperienced, there is no reason why this cannot be put right this season.

M. APPLEBY, (Capt.)

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of **Registrar in the Department of Minor Oral Surgery,** to attend on three sessions per week, with duties to commence as soon as possible until 30th September, 1967. Forms of application are obtainable from, and should be lodged with, The Superintendent, Guy's Hospital, London, S.E.1, not later than **Friday, 14th October, 1966.**

GUY'S GROUP
ST. OLAVE'S HOSPITAL

Applications are invited for the post of **Medical Registrar at St. Olave's Hospital,** with duties commencing 22nd October, 1966, or as soon as possible thereafter, and appointment to 30th September, 1967 in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **10th October, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Surgical Registrar,** with duties commencing as soon as possible and appointment until 30th September, 1967 in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned not later than **10th October, 1966.**

PASS LISTS

We apologize that the following names were omitted from our previous lists.

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PERSONAL

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CHANGE OF ADDRESS

Dr. R. K. R. Innes, Anestesi Aodelingen, Rikshospitalet, Oslo, Norway.

BIRTHS

HORNIBLOW.—To Molly and Arthur Hornibiow, a daughter, Emma Charlotte, on 27th June, 1966, sister for James, Richard, Sarah and John.

JOHNSON.—On 6th September, 1966, in North Vancouver, British Columbia, to Ann (née Carvell) and Miles Johnson, a daughter, Sarah Jane.

DEATH

FERGUSON.—Mary Ruth Ferguson, on 7th September, 1966, after a long illness. Miss Ferguson, qualified at Guy's in 1925.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

EDITORS M. F. D'SOUZA and D. S. ROBINS

SPORTS CORRESPONDENT G. E. RATCLIFFE

NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2040

PASSIM

Dr. P. J. Helliwell to become next Superintendent

At a meeting of the Board of Governors on Monday, the 3rd of October, Dr. P. J. Helliwell was appointed to become the next Superintendent of the Hospital, commencing on the 3rd February, 1967, being Superintendent Designate from the 1st of November, 1966.

Mr. Blaikley who, after being ill, recently resigned as Superintendent in order to assume full clinical duties again, was the guest of honour at a party given by the Governors in the East Wing on the 15th of September. This was attended by most of the staff of the Hospital and Schools and Lord Robens presented Mr. Blaikley with an antique chest of drawers, a gift of his own choosing, as a token of the hospital's great indebtedness to him.

Mr. Cann, appointed Acting Superintendent during Mr. Blaikley's illness, has continued in this capacity subsequent to Mr. Blaikley's resignation; the Governors have placed on record their very high appreciation of Mr. Cann's assistance in undertaking this arduous job until a permanent appointment could be made. On the 3rd of February, Mr. Cann will resume his position on the Board of Governors which he had to temporarily give up during this period.

On behalf of all at Guy's, the *Gazette* would like to express the wellwishes of everyone in the Hospital to Mr. Blaikley for a happy continuance of his clinical life relieved of the burdens of administration. We would like to congratulate Dr. Helliwell on his forthcoming appointment during this important and exciting time of redevelopment, and we do hope that the waters will run smoothly for him. We would like also to add our appreciation to that of the Governors for Mr. Cann's service to the hospital in taking on this most difficult post, first when he was looking forward to a well-earned retirement. He must know that he will carry with him the affection and gratitude of everyone at Guy's when he eventually is allowed to enjoy his retirement to the full.

Not just hello

The freshers have arrived. They have been tead, coffeed and may soon be wined. They have been fêted, exhorted to strengthen or give some justification for the existence of, and in some cases provide committees for the various clubs and societies of Guy's. Some have cynicism, some will achieve cynicism and some will have cynicism thrust upon them. But they will have been welcomed.

After between eighteen months and two and a half years, for a few still longer, they will again be freshers—clinical freshers. Here they will again be lectured and exhorted to all manner of good deeds, suffer pet theories on approach, application and adjustment, and will be superficially introduced to the various departments. Again they will be lost at first, soon learn how to get on with nurses, and eventually get down to some studying.

The third and final stage of introduction is a series. Excluding their special appointments, they will on nine occasions start a new firm with new teachers, housemen and ward staffs, and on nine occasions they are likely to notice the absence of full introduction. They will read slowly through out-of-date scraps of paper on ward notice boards regarding ward duties and timetables, take a variable length of time to discover the names of their registrars, longer to get their names and faces united as one in consultant minds, commit faux pas through ignorance in theatres and will continue to pester nursing staff on the localities of various items in wards and out-patients departments for some weeks to come. In short, the correlation coefficient between complete introduction and personal initiative will come very close to unity.

But they will not complain. They and many others are only too used to the norm of the Monday brief nod on passing in the park from the person whose house guest they have been the previous week-end. And this in spite of the fact that this is Britain, a country noted in other parts of the world for being peopled by a civilized nation with a particular reputation for good manners.

The question comes at the end. It is, of course, one of approach. We have perfected the art of farewells; we honour and pay people appropriately in the latter part of their lives and on the whole the cemeteries are in a better state of repair, staffing and management than the maternity homes. The prevailing attitude is basically retrospective. So with the clinical firms. We say farewell in grand style with firm dinners. Can we not learn how better to say hello?

The Biennial Dinner

On Friday, the 7th of October, the Hospital held its Biennial Dinner in the Grand Hall of the Connaught Rooms, Kingsway. Sir Rowan Boland was the chairman for the occasion, which was attended by about four hundred and fifty Old Guy's Men, whose dates of qualification ranged from 1911 to 1966. Organised by Mr. Eckhoff, with the indispensable assistance of Mr. Goodliffe, the dinner was a great all-Guy's occasion. The menu was simple and excellent, the company nostalgic.

We feel that perhaps not enough Old Guy's Men are aware that this dinner is such an excellent opportunity for reviving old memories and acquaintances. And we hope that at the next one, in two years' time, there will be an even greater attendance than there was on this occasion.

House Appointments

It has been decided to postpone the first phase of the change in the house appointments system until March 1st, 1967, with the exception of the appointment of three post registration casualty officers. The full details are to be obtained on page 529.

PROFESSOR R. W. B. ELLIS

It is with much sorrow that we record the recent death of Professor Ellis, known and loved by many Guy's men and women.

DR. JAMES STEPHENS

The death occurred on 20th September, 1966, in Colorado, of Dr. James Stephens. He qualified from Guy's in 1942 and was House Physician and Registrar in Neurology both here and later at the National Hospital, Queen Square. In 1953 he became Assistant Professor of Neurology at the University of Colorado, in the United States, where he had a distinguished career in Neurology, serving on a number of Advisory Boards, and in 1962 became head of the division of Neurology at that University. His death will be a great loss to Neurology and he will be sadly missed by his friends both in the United States of America and in this country.

GUY'S DIARY

OCTOBER Exhibition :			"Goitre". This and all future exhibitions will be held in the Gordon Museum and not in New Guy's house as before.
18th	Tu.	1.00	Clinical lecture : Mr. BEARD. "Diverticulitis Coli".
		5.00	Films in the Anatomical Theatre. "Instinct and Reaction" and "Reason over Reflex".
21st	F.	1.00	Clinical lecture : Dr. MACLEAN. "Shock and its Treatment".
22nd	Sa.	10.00	Clinico Pathological Meeting, Clinical Theatre.
24th	M.	1.00	Clinical lecture : Mr. BLACKBURN. "Gastro-intestinal Bleeding".
25th	Tu.	1.00	Clinical lecture : Dr. JOINER.
27th	Th.	1.00	Clinical lecture : Mr. WASS. "Swellings in the Scrotum".
28th	F.	1.00	Clinical lecture : Dr. KAUNTZE. "Sub-acute Bacterial Endocarditis".

THE GERIATRIC DEPARTMENT OF GUY'S AT NEW CROSS HOSPITAL

By A. J. Rosin

Consultant Physician in Geriatrics

In 19th century Britain, the Workhouse Infirmary was the place where aged sick people were cared for, unless they were wealthy enough to afford private treatment. There they lingered with the destitute and disabled, and once they became bedridden, they rarely emerged from the Infirmary.

During the past 30 years the idea developed that elderly sick required treatment as well as care. When the infirmary wards came under the wing of the municipal hospitals in 1929, the latter "inherited" a large number of chronic sick patients. It was shown by some of the pioneers in geriatrics such as the late Dr. Marjory Warren, in charge of the chronic wards of West Middlesex Hospital, that some of these patients were neither chronic nor sick. A number were found to have remediable disabilities and recovered sufficiently to be discharged. It slowly became recognised among hospital authorities that specialised attention to the problems of illness in old age could produce better results in the patients.

Departments of geriatrics began to be established, sometimes within general hospitals, and sometimes arising from disused wards in hospital annexes or in the country branches of hospitals. In recent years some tuberculosis or fever hospitals have been converted for this purpose.

This article deals with the scope, function and running of a modern geriatric unit as illustrated by a year's work at New Cross Hospital.

New Cross Hospital was a fever hospital before the Second World War, but, after being damaged in the war, remained derelict until 1952, when one ward was opened for geriatric patients. The only other hospital accommodation for geriatric patients in the area was in the two chronic sick wards in St. Olave's Hospital, and the Bermondsey Medical Mission Hospital. Dr. Barbara Morton, who was in charge of the Mission Hospital, began to expand the ward accommodation in New Cross Hospital, and Dr. Mary Nixon, of St. Olave's Hospital,

visited the old people at home, and gradually reduced the waiting list for a geriatric hospital bed.

By the early 1960's, New Cross Hospital had five geriatric wards, under the charge of Dr. Margaret Upton. In addition it now contained an active medical unit, an expanding physical medicine department and some general surgical wards from Guy's, accommodated there during the building of New Guy's House. The greater demands for geriatric services in the hospital and its catchment area necessitated increasing the senior and junior medical staff and these appointments were made towards the end of 1964.

FUNCTIONS OF A GERIATRIC DEPARTMENT.

The special facilities of a geriatric unit derive not only from special apparatus or techniques but also from the attitudes of the staff to old people, the organization of the wards, and the various connections the unit has with bodies outside the hospital dealing with welfare of the aged.

In a geriatric unit, the presentation and natural history of disease in old age can be observed in detail. This sometimes differs from that in younger people, e.g., mental confusion is more often an early feature in many physical illnesses of the elderly. Old people respond differently to some drugs, e.g., greater sensitivity to digitalis. Prescriptions of drugs to old people at home must take account of the old person's ability to administer them, e.g., memory, eyesight and intelligence.

Much of the work in a geriatric unit is concerned with rehabilitative measures. In addition to the clinical diagnosis, it is necessary to make a comprehensive assessment of the patient's abilities of self-care. The aim of hospital treatment is to restore function. This often means more than alleviating the disease causing admission to hospital. For example, a fractured femur may unite, but the loss of balance due to cerebral ischaemia may render that patient unable to walk. The rehabilitative programme is then directed more to the disturbance of balance and to the mental state, than to the mechanics of the united fracture.

Correct placing of disabled old people forms an important part of the work. Increased supportive services at home may be needed. Some patients may require a more protective environment to go to on discharge from hospital than their original home background. Some hospital patients are more properly suited to live in residential homes, and vice versa. The clinician must have a working knowledge of local community services, such as the local authority health and welfare departments and voluntary organizations so that he can direct the appropriate type of help to the correct patient. A geriatric unit must also take responsibility for a large number of long-stay patients. It may be weeks or even months before it becomes clear that some elderly patients will be entirely unfit for discharge from hospital. The management of such chronic illness and the maintenance of a cheerful ward atmosphere are among the qualities required of a geriatric team.

WORK OF THE YEAR.

In 1965 there were 383 admissions, 253 discharges and 130 deaths in the geriatric wards. Table I shows the sources from which the patients were admitted. Excluding 9 patients who returned after referral to other wards, there were 119 males and 254 females. Seventeen of the admissions were in exchange for patients discharged. These exchanges took place if a resident in a Welfare Home or half-way house became ill enough to require hospital care. Nearly one-fifth of all admissions were transfers from general medical or surgical wards. Over three-quarters of the group were admitted directly from home.

Table I—Sources of admission, 1965

Own home	Transfer from Hospital	Transfer back from other departments	Half-way house (Homefield)	Welfare Home	Total
298	60	9	8	8	383
78%	15.7%	2.4%	2.1%	2.1%	
		19			

The Age Structure is shown in Table II. The largest group is in the 75–84 decade, but 18% were aged over 85. The age range shown is typical of most geriatric units and reflects the higher life expectancy of today with increasing incidence of degenerative diseases late in life.

Table II—Age structure

Less than 65	65–74	75–84	85–89	90–95	95+	
9	30	61	11	0	1	Males
12	53	133	37	13	3	Females

OUTCOME OF PATIENTS ADMITTED IN 1965.

Although Table I shows that 253 patients were discharged during the year, this includes some patients admitted before 1965. The actual outcome of the 374 new admissions was as follows:—

Table III—Outcome

	No.	Per cent.
Home	187	50
Half-way House (Homefield) ...	8	6
Welfare Homes	8	
Other Homes	5	
Other Hospitals	8	2
Long-stay	60	16
Death (male)	42	25
(female)	50	

Fifty per cent went home—131 (52%) of the women and 45 (47%) of the men. The proportion who became long-stay patients was about one-sixth—a much smaller number than is generally imagined in general wards. Up to three months after the end of the year, the mortality of 374 admissions was 25%. Death within one month after admission occurred more often than later—an indication of the high proportion of acute cases, or those with terminal illness. The number of deaths in the first six months were as follows:—

Table IV—Mortality of new admissions, January—June, 1965

Death within 2 weeks	4 weeks	6 weeks	8 weeks	12 weeks	more than 12 weeks
28	7	4	1	3	11

An estimate was made of the length of stay of those discharged, and the Table shows the figures for the first six months.

Table V—Length of stay of in-patients who were discharged January—June, 1965

2 weeks	4 weeks	6 weeks	8 weeks	12 weeks	more than 12 weeks
20	37	17	10	0	11

The chances of discharge appear to become less after a stay of 2 months. The 11% who went out after being in hospital for 3 months or more represent those requiring prolonged rehabilitation. Sometimes attempts to send an old person out of hospital are difficult because of the nature of their disability, or of their home environment. Six patients during the year were re-admitted soon after their discharge because they were unfit to be at home. A further 7 died within 2 weeks of leaving hospital. These failures can sometimes be anticipated, but the variability of prognosis can cause errors in forecasting. For example, one 80-year-old woman with a recovering confusional state due to senile dementia went home, to be re-admitted three days later with a cerebral haemorrhage from which she died.

HOLIDAY ADMISSIONS.

A geriatric department should help relatives who are caring for disabled old people, as well as treat aged patients. Part of this help consists of admitting the old person for a pre-arranged period while the relatives have a holiday. Twenty-three such patients were accommodated during the summer months, 16 women and 7 men. One became a long-stay patient and 7 others were re-admitted after their return home. The period of stay averaged about $2\frac{1}{2}$ weeks, but was prolonged in some cases because of unfitness for discharge. Three

other patients were admitted intermittently by arrangement with the relatives—a sharing of the nursing care between home and hospital. These "holiday" patients were selected by a pre-admission assessment visit as requiring medical attention as well as supervision. The Welfare Department of the local authority arrange holiday admissions to residential Homes for fitter old people.

Fig. 1.—Part of the Art Therapy class at New Cross Hospital. As well as diversional activity, the class serves as a useful addition to the diagnostic assessment of selected patients.

RE-ADMISSION

The degenerative nature and multiplicity of illness in old age render re-admission to hospital inevitable in many cases. Of the 313 new admissions in the 10-month period January—October, there was a total of 83 re-admissions (26%)—63 within 6 months of discharge and 20 between 6 and 12 months of leaving hospital. This figure, estimated 2 months after the end of the year, would be higher in a longer follow-up. The number of 83 re-admissions represents 51 patients returning once, 12 patients returning twice and three others were re-admitted as a planned intermittent arrangement with the relatives on 8 occasions. Thirteen of the 83 patients were re-admitted to a different hospital or a different ward. The cause of re-admission is not necessarily a relapse of the original condition precipitating admission. Forty-eight re-admissions were for the same condition as before and 32 were due to different illness. Sometimes the same patient was re-admitted twice, e.g., a woman with a respiratory infection and anaemia was re-admitted once for a recurrance of the bronchitis and several months later with a myocardial infarct. Approximately half the number of re-admissions were again discharged during the year but nearly a quarter died.

STRUCTURE OF GERIATRIC DEPARTMENT.

A geriatric unit in a hospital forms a co-ordinating link in the wider pattern of community care of the elderly. This dynamic concept is in contrast to the former passive attitude of caring for the chronic sick. A geriatric problem embodies clinical, pathological, psychological and social aspects. The doctor dealing with elderly ill people should assess fully each of these aspects before planning a suitable therapeutic programme, which may range from retraining the patient's walking rhythm to finding suitable housing for him. The aspects of potential function are emphasised as well as those of residual disease and disability and these are translated into the performance of basic tasks of daily living, washing, dressing, etc.

Fig. 2.—Rehabilitation in the ward, with the use of portable parallel bars. The patient, a recovering right hemiplegic, is being taught to lean on his unaffected side.

PROGRESSIVE PATIENT CARE.

The course of illness in hospital is marked by different stages—the acute phase, recovery, convalescence. These stages may be spread over a longer period in the elderly than in the younger patient. It has been found useful to adapt different wards of a geriatric unit or even different parts of the same ward to the patient's changing medical, nursing and functional needs at the various phases of his recovery. In New Cross, most patients are admitted to the active admission wards. From there, they either return home if the illness is of short duration, or if rehabilitative measures are required over a longer period, they are moved to a rehabilitation ward. The accent in this ward is on mobilising procedures, training in basic daily tasks such as dressing, getting on and off the bed, wheelchair drill, and walking. The patient may go home from there, or if further supervision is required, a place in the Half-way House (Homefield) may be found for her. Here, the patients might require supervision without the nursing needs of a hospital ward; they also have the opportunity to experience life out of hospital before facing the rigours of being left in their own home. Two-and-a-half of the five wards at New Cross, and two wards in St. Olave's Hospital are for long-stay patients. The other wards also carry a complement of long-stay cases. It is reckoned that about one-third of the beds of a geriatric unit should maintain a turnover to provide facilities for clinical investigation, functional assessment and rehabilitation.

The nursing staff should be orientated towards helping the patients to self-care. Physiotherapy plays a great part in treatment, and at New Cross, the skilled physiotherapy is supplemented by the useful services of lay assistants who are able to spend time with the individual patients in the ward and achieve a successful rapport with them. Occupational and group therapy are of importance both in rehabilitation and long-stay wards. In the latter, enjoyment of life may yet be found for those confined in four hospital walls, and a passive existence may yield to active interest during the declining years.

THE FUTURE

There is increasing interest in the care of ageing people, from the highest levels in the Government to local community projects. In this context there is much scope for the hospital service, both in streamlining its in-patient facilities by better patient care, and in its co-operation with community services.

The fruits of clinical and social research in illness in old people might make "medicated survival" worthwhile.

BOOK REVIEW

" A NEW LOOK AT CHILD HEALTH."

By Michael Joseph, M.D., M.R.C.P., and Ronald C. Mackeith, D.M., F.R.C.P. Publisher—Pitman Medical. *Price* 15*s*.

"A New Look at Child Health" gives a stimulating account of the basic concepts of Paediatrics and an authoritative reappraisal of practical measures designed to meet the medical needs of children.

It is a book which will be of value to a large number of people even if they are not aspiring paediatricians, and will provide greater insight into the special problems of children's care.

The essence of the work is well summarised in the foreword by Dr. Evans, who writes that in paediatrics "so much has changed that the purpose and tasks of the speciality have to be thought out again". This is a wide field to cover in a small book of 124 pages, but the authors have succeeded in marshalling the facts and presenting their arguments and conclusions in well-written English that is easy to read. My only criticism is of the lack of a subject index, which is a useful part of a book such as this and would make reference easier.

In the earlier chapters the authors give an excellent description of what paediatrics is, and what its aims and methods are. They deal mainly with the evolution of paediatrics as a branch from medicine and a speciality in its own right. How the study of the child as an organism which is progressively changing and developing in its constituent functions and as a whole has led to basic concepts that differ fundamentally from those determining the practice of medicine in the adult.

The application of these principles to the numerous practical problems in the medical, educational and social care of children are next developed. Where present attitudes and facilities fall short of the ideal and attainable, remedial measures are clearly and unequivocally pointed out. In this country much has already been done towards the attainment of higher standards but there is still room for improvement as standards are continually being raised by the speed of advance of medical knowledge and their attainment hampered by the difficulties of putting knowledge into practice.

In the later chapters the authors consider individually the roles of those who have responsibilities for children and of available services. The three main divisions of the Health Service—hospitals, family doctors and local health authorities—come in for close scrutiny, and their organization, quality and present defects are analysed and constructively criticised.

As nearly every important aspect of paediatrics and its sub-divisions is discussed, the book will inform and interest all who are working in this field. The fact that some of the later chapters may have more interest than others for those working in different branches of paediatrics is unavoidable, and does not detract from the book as a whole. If the authors had restricted the book to subjects of general interest it would have lost much of its impact and value as a comprehensive appreciation. Not only will students and residents find the basic facts of paediatrics in this book, but senior hospital staff and specialists whose contacts with children are only incidental, will find a great deal that is thought-provoking and helpful.

Finally, and with special emphasis, I would commend it to the administrators of our hospitals and health services on account of its lucid explanation of the reasons and principles which should form the basis for planning facilities for children.

Altogether it is an excellent book and one which makes a timely and important contribution to medical thought.

P. N. SWIFT.

Princess Margaret signs the visitors' book while Matron looks on.

A patriot for us.

NOTICE

Hospital Chapel

The Hospital Chapel will be closed from October 10th for approximately six weeks for building work to be carried out. Arrangements have been made for services to be held in the Senior Common Room, second floor, New Guy's House, which will become a temporary chapel during this time. This room will be reserved solely for the Chaplain's use until the Chapel is re-opened.

R. J. CANN,
Acting Superintendent.

4th October, 1966.

CORRESPONDENCE

Miss Hilda Doris Chrimes, S.R.N.

SIR,—As many readers will already be aware, Miss Chrimes retired from the Nursing Staff of Guy's on 16th July, 1966.

Miss Chrimes joined the Guy's Hospital School of Nursing on 15th June, 1932, and upon becoming State Registered, she held an appointment as a Staff Nurse until 1937, before joining a private Nursing Co-operative Association. In 1940, Miss Chrimes returned to Guy's and held a variety of appointments not only at Guy's itself, but also at the Base Hospitals which were then being maintained during the war. These included the sectors at Farnborough, Pembury, Sevenoaks and Orpington.

In 1945, Miss Chrimes returned to Guy's and was appointed as a Sister in Charge of a Male Medical Ward. In subsequent years she held a further variety of appointments, and in 1957 became the Sister in Charge of the Out-patient Department, where she remained until her retirement in July, 1966.

A tribute to Miss Chrimes appeared in the *Gazette* of the 6th of August. Nevertheless, I would not wish anybody to be unaware that the sole reason why this letter has been deferred is in order to comply with the express personal wishes of Miss Chrimes. I have now obtained a suitable book in which I will be happy to collect the signatures of those people who would like to sign their names and make a farewell financial gesture. I have divided the book into three sections:

1. Nursing Staff: Past and Present.
2. Medical Staff: Past and Present.
3. Other Friends.

This book will remain available in the Matron's Office until 31st January, 1967. Cheques should be made payable to "Guy's Hospital."

Yours, etc.,

ANNE M. JOHNSON.

Matron's Office,
Guy's Hospital, London, S.E.1.

We'll keep a welcome in the Valleys

SIR,—You record that the unruly behaviour of certain students is becoming a matter of concern at the Hospital.

I should have thought that one measure which could be adopted to correct this nuisance is to cease accepting Welsh Nationals in the Medical and Dental Schools.

Yours, etc.,

B. A. TUDGAY.

Belmont Surgery,
Wadhurst, Sussex.

Teaching saves lives

SIR,—May I pay tribute to Professor Spurrell from the other side of the globe?

On a hot summer's day he was lecturing to an inattentive audience, and in exasperation he warned us that one day when we were weary and lost after a long day's work, we would look in our physiology books and there find what had been eluding us all day.

Several years ago I asked a colleague to see a child who had had a tracheostomy for laryngeal stridor. He replied that I had done everything possible, but he thought that the child would die. It was at this moment that I remembered Professor Spurrell's words and we followed his advice and found what had eluded us both. The child's electrolytes were corrected by an intravenous drip and he rapidly improved within an hour.

I wonder how many other lives have been saved by his teachings?

Yours, etc.,

COLIN D. CHILVERS

P.O.Box 14,
Wairoa, H.B.,
New Zealand.

Dontal Edjucation

SIR,—Having read the correspondence in the last issue of the *Gazette*, may I implore that the new concepts in Dental Education will include a course in elementary spelling.

Yours, etc.,

CLIVE DEBENHAM.

1, Harley Street,
London, W.1.
6th October, 1966.

Nurses' Uniforms

SIR,—I was interested to read in the last issue of the *Gazette* the article "*Democracy and Co-operation*", *contributed by your nursing correspondent*.

Being interested in Hospital uniforms and the tradition of the large teaching hospitals, I was sorry to learn that she wishes the uniform to be changed.

It is quite incorrect to write that a Guy's nurse is wearing the same style uniform of that of fifty years ago. Although my memory only goes back to the thirties, the uniform was vastly different, high starched collars, starched cuffs, and long sleeves were the order of the day. The discipline too was different, but that is another story.

I consider it would be a very retrograde step if the Hospitals were to do away with their own individual uniforms and abandon their great traditions.

Furthermore, if they did so, it is my opinion that there would be a falling off in the numbers of girls of the calibre Guy's and the other teaching hospitals are requiring, who desire to train for the nursing profession.

As an example of Hospitals having their own individual uniforms, Guy's Hospital recently published a very handsome booklet on their School of Nursing. Page 12 shows a patient undergoing a transfusion. It may not be generally known that the photograph is now being used by the Ministry of Health in an endeavour to recruit blood donors, and it must be a source of satisfaction to anyone connected with the Hospital to know that it is a Guy's picture being used.

It was nice to learn from your correspondent that the nurses themselves are so intolerant of change.

It may interest your correspondent to learn that most liners carry two or more nursing sisters on board. They have two uniforms, white for the Mediterranean and the Tropics, and blue for the Atlantic. It is a remarkable fact that although these nurses can usually choose their own style uniform, when they don their blues it is not unusual to see them appear wearing a high starched collar, and starched cuffs, despite all we read and hear about starch, etc.

Yours, etc.,

F. JOHN PITTS

7, De Montfort Road,
Streatham,
London, S.W.16.

SIR,—I would be grateful if you would publish my comments on the article in the Nursing Section of the recent *Gazette*, parts of which appear to be singularly uninformed. "Change" is not a new phenomenon at Guy's. It has been continuous throughout its history. When I tell people that I worked at Guy's for nearly forty years, they invariably remark, "You must have seen many changes." I am sure the writer would agree that change is justified only if it brings improvement, that is, better nursing care of the patient. It is disturbing to read that one should "forget the old ideas." A tree cannot live without its roots, and we all know that when the bath water is thrown away it is desirable to save the baby. By all means let in fresh air, but "the cold blast of air blowing through" fills me with trepidation for the comfort of those within.

Inculcation of a sense of responsibility has always been foremost in the nurses' training. Having our own patients ensured this, which was most rewarding and appreciated by the patients. When I was a nurse there were only four staff nurses in the hospital. This meant that the Head Nurse in her third year was in charge of the ward during Sister's week-ends and holidays. Some of the old Sisters were autocrats, many were leaders, but I never met one who did not work with her nurses in one way or another.

It would be interesting to publish photographs of a nurse of fifty years ago by the side of one of to-day. The uniform to-day appears to consist of a plain, almost 'mini' cotton dress (not much starch), a cap and strings, with an apron for the ward. It is difficult to see what could be discarded. Please keep the strings.

From time immemorial nurses of one generation have tended to decry the merits of another. It will be ever thus, but need not be taken too seriously. Each generation has its peculiar difficulties, and I am convinced that the present Guy's nurses will overcome their difficulties and that the spirit of Guy's will never change.

Yours, etc.,

FLORENCE TAYLOR.

103, Blackheath Park, S.E.3.

"A" Level Biology Syllabus

SIR,—The new "A" level London Biology Syllabus came into force this time last year. Teachers then complained of inadequate notice of the change, and many were resistant to it. Recent soundings show that this phase has passed, and both teachers and their pupils are finding a new freedom and new interest within the framework of the new syllabus. To them and others the following morsel is dedicated:

On the Anniversary of a Brainchild.

'Tis but one year since first he saw the light of day,
Arriving late, too late for us to say:
"Fear not this lusty infant, though he should appear
So different from his kin of yesteryear."

Conceived in the watches of the night when owls do snooze,
We sought not thus to baffle or bemuse
Our colleagues in their schools,
But t'encourage them to use
Their special skills, freed from the trammels
Of type-teaching atypical "types",
The repetition of whose parts
Had become a ritual, and the arts
Of using hand and eye had perished
In the stagnant mire of repetitious lie.

Come! Give him time to grow in limb and girth,
And let our brainchild prove his living worth!

Yours, etc.,

E. W. BAXTER.

Biology Department,
Guy's Hospital Medical School.

Professor R. W. B. Ellis, O.B.E., M.D., F.R.C.P.

SIR,—I was privileged to be the Sister of Diplock Ward from the time Dr. Ellis (as he then was) was appointed Physician in charge of the Children's Department at Guy's until he left to join the R.A.F.V.R. soon after the Children's Ward had been evacuated to Pembury Hospital in the early days of World War II.

He was delightful to work for and with, and fired students and staff alike with his tremendous enthusiasm for promoting child health. He loved the children, and took such a personal interest in them, and they instinctively loved him.

To the nursing staff he was a great teacher, with a gentle, kindly manner, sense of humour and wonderful powers of diagnosis and treatment of his patients.

After our evacuation to Pembury, he was the greatest possible help and support in the early, difficult days of evacuation. Obtaining adequate equipment and supplies was no mean achievement, and it was largely owing to his persuasive purposeful activity that we were enabled to give a reasonable standard of patient care and nurse training.

I am sure that all Guy's nurses who were privileged to work with him will feel a profound gratitude combined with a great sense of loss.

Yours, etc.,

(Miss) EVELYN A. OPIE,
Guy's (1926-1947).

Hillside, Dibden,
Nr. Southampton

Before the Lamps go out

SIR,—Looking at the letter in your issue of October 1st from Mr. D. London, it occurred to me that the ideal dental surgeon is a rare find. I agree with Mr. London about tooth carving and all its significance.

The man who enters the dental profession does so because of several things. He may have some hereditary flair and perhaps a practice to step into and so on. Or he may like the job for itself, and in that case he will have the mind of a craftsman. But he also must have patience and humour with the virtues of a family doctor.

In my own case, being at a loose end, it was quite by chance I met my friend Charles Edney, whom I had met during the first Great War for civilisation. He said: "Why not come up to Guy's?" . . . . .

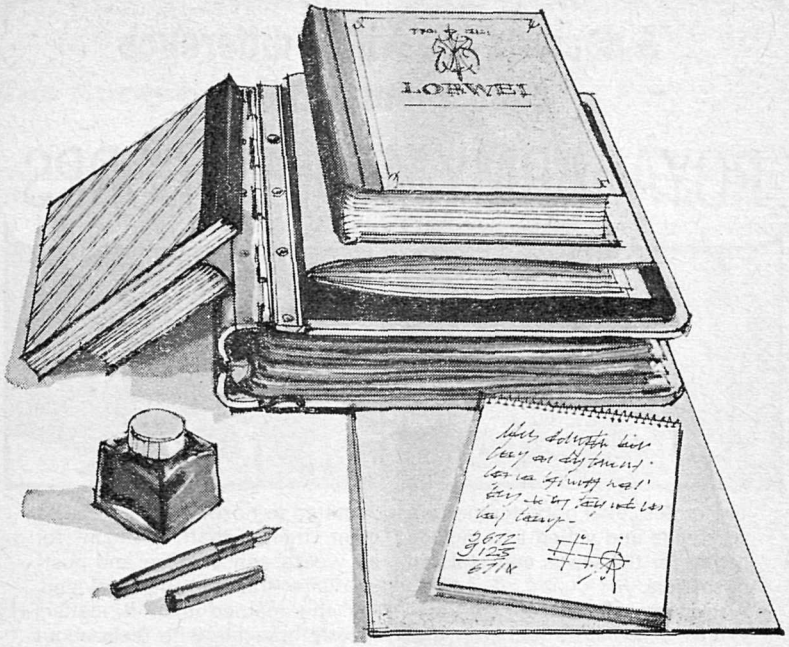
The period between the wars was in many ways a period of frustration mixed with excitement. With nostalgia for the happy days before 1914 when I crammed for the Little Go, I sat in my surgery waiting for patients. If I had had no responsibilities in England I should have packed up and gone looking for pearls on the Great Barrier Reef.

Looking at the contemporary scene, it does seem to be full of promise with its strong political slant (if slant is the word). With its proliferation of universities and professors growing on tops of trees, the Government, if it is wise, should give largely a free hand to the older academic authorities who have the knowledge and know-how to enable them to put forward suitable men for doctors and dentists—before the lamps go out.

Yours, etc.,

JOHN C. DOMINICK.

Treniffle Lodge,
Lawhitton,
Nr. Launceston,
Cornwall.



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NURSING SECTION

The Nurses' Prize-giving 1966

At 3.10 p.m. on October 4th, 1966, H.R.H. The Princess Margaret, Countess of Snowdon, with Lady Juliet Smith in attendance, arrived at Nuffield House of Guy's Hospital, to present the prizes at the Nurses' Prize-giving.

Mr. A. E. Orchard-Lisle, the Vice-Chairman of the Board of Governors, met Her Royal Highness, The Princess Margaret and presented Miss A. M. Johnson, Matron, Mr. R. J. Cann, the Acting Superintendent, and Mr. A. H. Burfoot, the Clerk to the Governors.

The following persons were presented within the House:—

Squadron Leader F. H. Bowyer and Mrs. Bowyer.
Mrs. I. Brook.
Mrs. A. H. Burfoot.
Mrs. R. J. Cann.
Mr. C. A. Chadwyck-Healey and Mrs. Chadwyck-Healey.
Mr. J. Fairley and Mrs. Fairley.
Mr. R. Hayward and Mrs. Hayward.
Dr. J. C. Houston.
Sister B. B. Whyte.
Sister P. C. Asquith.

Her Royal Highness was then conducted to the Physiology Theatre to attend the Prize-giving.

A bouquet of flowers in Guy's colours was presented to The Princess by Miss Margaret Davis.

Mr. A. E. Orchard-Lisle, the Vice-Chairman of the Board of Governors, welcomed the Princess. He stressed how greatly her presence was appreciated.

The Vice-Chairman continued with introductory remarks and made comments concerning the fact that never in the history of Guy's Hospital had there been so much planned for the future. Mr. Orchard-Lisle commented upon the dedication of the Board of Governors, led by Lord Robens, and their interest, patience and understanding in maintaining a balance between teaching, training and staffing.

H.R.H. The Princess Margaret then addressed the assembly:—

"I am very happy to be here today for your Annual Prize-giving. The past year has seen many changes in the nurse training programme. It is a real challenge to have to meet the demands of present-day nursing and it is typical of this Hospital's illustrious past, that it is always ready to take a lead in tackling the problems of the future.

"You must be very fortunate to have received your training in one of our great Teaching Hospitals with all the special opportunities which it offers. Nowadays, the rapid advances made by medical science mean that it is necessary to have high academic standards as well as technical knowledge. These attributes, vital though they are, do not automatically make a first-class nurse in themselves. They must always be reinforced by other qualities. Perseverance and the ability to see each patient, not merely as a case, but as a person. One of the strengths of a Hospital with a history and tradition, is that in spite of its size, its members are bound together by a close family feeling which lasts the rest of their lives. Nurses have gone out from here to hospitals not only in this country, but all over the world, and the very high respect and affection in which their profession is held is due to the efforts made by each individual to maintain the highest possible standards, even in difficult conditions.

"I should like to congratulate all the winners of the prizes and awards, and to wish you all the utmost happiness in the future."

Following Princess Margaret's address, Matron then presented her report.

Matron added the welcome of the Nursing Staff to the remarks made by Mr. Orchard-Lisle when greeting the Princess. Matron then assured those present how delighted she was to have them at Guy's on such a unique occasion. Matron stressed her deep regret concerning the absence of Lord and Lady Robens overseas.

Matron then referred to some of the many changes which had taken place over the past year:—

1. The establishment of the Introductory Course at Guy's to train for the new Experimental syllabus of the General Nursing Council.

2. The introduction of the 42-hour week and the shift system of working hours.

3. The radical change in the pattern of night duty allowing a more normal routine for both patients and staff.

4. Alteration in the timetable of the patient's day.

5. The introduction of a programme of exchange with the student nurses of Guy's, St. Olave's and New Cross Hospitals.

6. Allocation of pupil nurses from the State Enrolled School at New Cross Hospital to the Evelina Hospital for paediatric experience. Matron then added that there was a united goal for the establishment of a General Nurse Training School and one State Enrolled Nurse Training School for the Group.

7. The discontinuation of the compulsory fourth year of training.

8. An increase in the number of Nursing Auxiliaries, coming from 8 different countries: there are now 24 Nursing Auxiliaries in post.

Matron commented as to how great a demand these changes had made on all sections of the community, but added the following figures for interest and indication of the value of new plans.

In January, 1964, 53 students entered the P.T.S. By September, 13 had left.

In January, 1965, 59 students entered the P.T.S. By September, 7 had gone.

In January, 1966, 73 students entered the new Introductory Course. By September only two had left.

Matron then turned to the subject of Post Registered Education. At the present time, Guy's offered only three Post-Registered Courses—Midwifery, Mental Nursing and Paediatrics. Matron hoped to implement Training Courses in the following subjects: (a) Intensive Care Nursing, (b) Theatre Courses, (c) For Theatre Technicans, (d) University Courses which, in view of the Salmon Report, might well include subjects relating to Business Management, (e) Geriatric Care.

Matron then stated that the Sisters of Guy's were second to none in the world and that nothing that could be done to alleviate their work load must remain unexplored. In Matron's opinion, the nursing profession of this country has tried too hard, and for too long, to fill too many gaps. The right use of nursing staff was a responsibility in which every branch of the Hospital Service must take its share. There was abundant evidence that the degree of caring is ever increasingly profound. If planning and research have outstripped the human resources which are available to staff new projects, we needed to look closely as to the means whereby the gap might be filled.

Matron ended her report by quoting Queen Victoria, who said, "We are not interested in possibilities of defeat—to us they do not and never will exist."

Reports on the School of Nursing were then given by Sister B. B. Whyte, Principal Nurse Tutor and Sister P. C. Asquith, Ward Sister.

Sister Brysson reported that during the year 1965/66, 197 nurses became State Registered, 223 nurses had started general training at Guy's and 15 nurses had entered post registration training either in Mental or Sick Children's Nursing. Although it was too early to draw any firm conclusions, there had been a marked drop in first year wastage since the new plan of training started.

Sister Brysson explained the apparent anomaly of two sets of medallists in pointing out that the training had been reduced from four years to three years.

The Sister Tutors and Ward Sisters of Guy's, St. Olave's and New Cross Hospitals had worked hard on the joint procedure committee and the agreements reached have been immense. This work, however, would take a number of years yet.

Sister P. C. Asquith said that the time spent in the wards by a nurse was the most valuable part of her training—because it is here that she meets and learns to care for that most important person—the patient. She not only learns the importance of carrying out medical instructions meticulously but she learns in time by listening to and talking to the patient during the course of his illness, to anticipate and understand the varied needs of the sick person—medical, physical and spiritual. These were the things that the nurse gets from the patient, but what does she give? She gives unfailing kindness, cheerfulness, sympathy and encouragement at times. Sister Asquith concluded by summing up the nurse-patient relationship in the words of our motto, "Dare Quam Accipere"—"It Is Better To Give Than To Receive".

The presentation of the Awards was then made by Her Royal Highness The Princess Margaret.

MEDALS FOR THE YEAR 1965-66

1962-66 School

CAZENOVE GOLD MEDAL	Miss Margaret Davis
Cazenove Silver Medal	Mrs. Hilary Eddleston (née Radford)
Cazenove Bronze Medal	Miss Alison Beveridge

1963-66 School

Cazenove Gold Medal	Miss Sandra Marsh
Cazenove Silver Medal	Miss Carol Fryer
Cazenove Bronze Medal	Miss Brenda Slade

Butterworth Medals

Miss Jacqueline Dungay	Miss Lydia Rea
Miss Gillian Glover	Miss Charlotte Taylor
Miss Wendy Morgan	Miss Veronica Taylor

The Jean Morton Award

1962-66 School	Miss Margaret Davis
1963-66 School	Miss Sandra Marsh

The Emily MacManus Prize

1962-66 School	Miss Anne Davies
1963-66 School	Mrs. Janice Walling (née Hughes)

PRIZE-WINNERS FOR THE YEAR 1965-66

Guy's Hospital School of Nursing

Miss A. Atkinson
Mrs. G. Bainbridge
Miss M. Beckett
Miss A. Beveridge
Miss C. Clark
Miss A. Clarke-Halifax
Miss C. Corfe
Miss J. Cox
Miss M. Davis
Miss A. Davies
Miss M. Edwards
Miss M. Featherstone
Miss E. Ferguson
Miss M. Finlay
Miss C. Fryer
Miss C. Fullman
Miss A. Gates
Miss T. Gumpert
Miss R. Horsfall
Miss A. Jones
Miss K. Jude
Miss P. Kemp
Miss E. Lampitt
Miss K. Legg
Miss C. Mackay
Miss S. Marsh
Mrs. J. McGregor
Miss S. Norris
Miss S. O'Keefe
Miss C. Phillips
Miss S. Pountney
Mrs. H. Eddleston
Miss J. Rees
Miss L. Shaw
Mrs. C. Skelton
Miss B. Slade
Miss A. Smith
Miss B. Stair
Miss C. Stratton
Miss E. Swales
Miss E. Thornton
Miss C. Vanson
Mrs. J. Walling
Miss H. Ward

Evelina Children's Hospital of Guy's Hospital School of Nursing

Miss M. Burlinson
Miss M. Osborn

The closing remarks were then made by the Acting Superintendent, Mr. R. J. Cann.

Mr. Cann thanked Her Royal Highness for coming to Guy's and so graciously presenting the awards to the nurses. Mr. Cann continued by saying that in his present post, it was apparent how much we all depended on each other. He suggested that as Guy's gave the nurses a very great deal so they, in their turn, should remember the motto on their Guy's Hospital Nurses' League Badge, and not leave the hospital prematurely.

After the Prize-giving, Her Royal Highness visited Ruth, Barnabas, Diplock and Caleb Wards. Walking through the Park the party reached the Colonnade and visited the Accounts Department on its way to Matron's Office, where the Princess signed the Visitors' Book.

Tea was taken in the East Wing, where several presentations were made. Her Royal Highness took tea with the Medallists and those who had won awards.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

S/N K. Beskeen to Out-Patients Department Annexe.
S/N J. Bennett to York Clinic.
S/N R. Boddy to Miriam Ward.

PROMOTION

C/N H. K. Eddleston (née Radford), S.R.N., promoted to Sister in the School of Nursing.

DEPARTURES

Sister C. Boyce from Clinical Tutor Evelina Hospital.
S/N D. Chapman from Nuffield Theatres.
S/N G. Collins from Main Theatres.
S/N F. Cowie from Main Theatres.
S/N W. Jones from Astley Cooper Ward.
S/N V. Stockdale from Main Theatres.

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* *Prog. in Biochem Pharmacol 1966 (In press)*

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SPORT

RUGBY FOOTBALL

Guy's have had two splendid matches during the last fortnight and are now developing into a very fine side, of which the hospital can be justly proud. A fortnight ago Guy's played and defeated United Services, Portsmouth, by 12 points to 8, in a very tense and exciting match. United Services have a very strong side this season with a fine, strong pack, including A. Davis, the England lock, who stimulated the senior side in the first England trial last Saturday. Elliott was the Guy's match winner with three fine penalty goals, and, with Rowlands scoring a fine try early on, Guy's held on desperately in the last few minutes to register a very fine win. Last Saturday, Guy's played the University at Cambridge and lost an exciting match by 8 points to 11.

Cambridge struggled home to win the closest contest between the sides for years. Guy's were very unlucky to lose with some doubt about the first Cambridge try, which came early in the second half when Guy's were leading by 5 points to 3. This try was converted, and Cambridge consolidated their position with another try to lead 11—5. Ross scored in the corner in the last few minutes to close the scoring. In the first half, Cheeseborough had scored under the posts after a fine movement.

One of the most pleasing points of the Portsmouth match was the crowd at H.O.P. From all accounts the stand was half-full, which is quite an improvement; with the new term having just started, we should like to invite all freshers not playing any sport, to H.O.P. to watch the hospital. Guy's have two more strong fixtures in the next fortnight, both at H.O.P. They play Bedford tomorrow and Metropolitan Police the following week; in their present form, Guy's are capable of defeating these clubs.

Charles Thorburn's ankle is mending well, and it is hoped that he will be playing fairly soon.

HOCKEY

Guy's have had two freshers' trials and a trial match with London Hospital; from these trials some quite promising newcomers became apparent. In their first full match of the season on Saturday, Guy's were defeated by South Saxons by the only goal of the match. However, the club are very keen and enthusiastic to improve on last season's record, and one hopes that over the next weeks they will settle into an accomplished and successful side.

SOCCER

Guy's have had a few pre-term matches with limited success, but now that term has started, Guy's soon start the more important fixtures in the University of London League. It is difficult at present to see how the team are shaping, but after a few league matches we shall be able to weigh up prospects for the University and United Hospital Cup Competitions. The side is perhaps not as strong as in previous years, but enthusiasm and confidence to do well won the U.H. Cup for Guy's last year, and several of last year's team are still at Guy's. The experience gained then should stand them in good stead.

SQUASH

Guy's were promoted last season to the 3rd Division of the Cumberland Cup, and hence their aim this season is to consolidate their position.

The chances of winning the Hospitals Cup appear quite reasonable, Guy's having to defeat the London to appear in the semi-final.

A full prospectus for the season appears below.

We should like to welcome all freshers to Guy's and trust that they will enjoy their sporting careers and activities whilst at Guy's. They will have ample opportunity and fine facilities for demonstrating their prowess in whatever field they partake.

Finally we must apologise to Dr. Burry for inadvertently referring to him as Dr. Buny in the last issue of the *Gazette*.

DIARY

RUGBY FOOTBALL.
October. Sat., 15th—Bedford. Home. 3.00.
Sat., 22nd—Metropolitan Police. Home. 3.00.

HOCKEY.
October. Sat., 15th—Teddington 2nd XI. Away.

ASSOCIATION FOOTBALL.
October. Sat., 15th—St. Mary's College. Home.
Wed., 19th—St. Thomas's Hospital. Home.
Sat., 22nd—Clare College, Cambridge. Away.
Wed., 26th—Queen Elizabeth College. Away.

RUGBY

GUY'S v. U.S. PORTSMOUTH

At H.O.P. 1st October, 1966
Result: won 12—8

In the past three seasons, in the equivalent fixture, the final score has read 6—3, 14—11, 13—15 in Guy's favour, so another close result was forecast. However, United Services came to H.O.P. this year with a very strong side, including the English international lock A. M. Davis, partnered by Eastwood, an international trialist. Goodwin and Lavelle in the pack and Gibson in the centre were other trialists playing; Gibson was partnered in the centre by the ex-Rugby League player, Jones.

Guy's kicked off into a slight breeze on a slippery ground before an encouragingly large crowd and were immediately pushed back on the defensive. The first scrum was taken by Portsmouth, against the head, and almost immediately an infringement by Guy's resulted in Lavelle's 35-yard penalty scraping the underside of the bar.

However, after about eight minutes play and against the run of the play, Rowlands received the ball from a ruck on the blindside and ran with great determination and skill to ground the ball far out on the right. The conversion attempt failed, but Guy's now woke up to their formidable task, and the pack played with more cohesion and speed onto the loose maul and began to equal their more experienced and heavier opponents. This was rewarded by a penalty against U.S. for a scrum infringement, which resulted in a fine angled 30-yard penalty kick from Elliott to put Guy's 6—0 up. However, United Services again swept back to the attack and a penalty attempt this time cracked high up against the post. The first half ended with United Services pressing hard and only one fine mark by Elliott under pressure and sensible defensive kicking and tackling by Elliott, Rowlands and Swift kept our line safe. Marsh, on the wing in his first game for Guy's, time and time again showed great determination and fearlessness in scything down his opposite number whenever he had the ball; in the pack Neville and Hughes toiled hard in the loose. In the final minutes of the first half Guy's moved out of their own half and Beacham was tackled only inches short of the line, and one other carefully planned move left U.S. flatfooted, but Elliott's attempted drop kick went wide.

Guy's played downhill in the second half, but U.S. maintained their dominance and only good covering by Rowlands, improved forward play and a long relieving kick by Williams, kept the Services out. However, the latter were themselves wasting many opportunities and one easy penalty kick just wide of the posts went astray. Elliott drop-kicked off, sending the ball the length of the pitch, but U.S. slowly worked their way back and a blindside break carried on by their forwards resulted in a try well converted from the touchline (6—5 to Guy's). Guy's, urged on by the crowd, fought back and Elliott, with another superb kick, capitalized on a scrum infringement. However, almost immediately Gigson broke through high half-hearted tackles to ground the ball behind Guy's line, the conversion attempt just veering wide of the posts—so Guy's now led 9—8.

With the tension now increasing, both on and off the field, Guy's scored again, once more through Elliott's boot, following a spirited dribble by Beacham, who did well to keep the ball in play. This dribble was foiled by a defender refusing to release the ball, thus giving Elliott his chance.

Now, with Guy's leading by 12 points to 8, and only ten minutes to go, the rest of the game belonged to Portsmouth for they gained practically every ball from the tight, loose and line-outs, and aided by weak tackling they pummelled Guy's line, and were only kept out by desperate covering.

The final whistle was greeted with relief, for Guy's had beaten a very strong side. However, Guy's had scored only one try to their opponents two, had seen two penalties strike their posts, and only the superior fitness and determination of a few of their team had saved the game at the end. Elliott was in fact the match winner, kicking three penalties from difficult angles.

Guy's: D. R. Elliott; S. A. Marsh, D. J. Osbourne, M. J. Cheeseborough, R. J. Beacham; B. J. Rowlands, P. G. F. Swift (Capt.); J. E. Davies, G. B. Hey, R. A. C. Hughes, A. J. Kingdon, J. M. Cockburn, P. Williams, C. G. Neville, D. A. Curzon.

H. C. SHARP

GUY'S v. OLD ASKEANS

At H.O.P. 24th September, 1966
Result: won 9—3

Guy's kicked off on a glorious sunny afternoon against a side whom they have never beaten. Guy's made four changes: Osbourne coming into the centre, replacing Lewis; Hughes coming into the front row for his first XV debut; Cockburn moving up to lock-forward, in place of Kingdon, struck down by some irritating bacillus; and Brown taking Cockburn's place at number eight.

The first few minutes play took place between the twenty-fives with no really positive moves being made by either side. In the lineouts the Guy's jumpers, Neville in particular, were having things very much their own way, but in the tight and loose the packs were far more equally balanced. However, as the game wore on Guy's gradually got on top and the backs were allowed to show their paces. Osbourne and Beacham were soon making some fine breaks in the centre, from one of which Guy's should have scored but the final pass to Morgan was badly timed. Another fine break

by Beacham was also spoilt by a poor pass. However, Guy's were not to be denied when after twenty-five minutes Ross scored in the corner after Guy's had heeled quickly from the loose. This was a fine try, particularly the way in which Ross broke out of a tackle before scoring. Elliott, whose kicking boots seem to have temporarily deserted him, failed to convert.

At this stage Guy's were well on top and this try encouraged them to throw the ball about a lot more and we saw some fine cross-field passing between backs and forwards. However, one such movement broke down in mid-field leaving the Guy's line virtually undefended; fortunately for Guy's the opponent who picked up the ball knocked on and hence was unable to start a movement which could well have resulted in an equalising try. The Old Askeans' backs had looked better in attack than defence and on occasions had looked quite dangerous.

Guy's continued to attack for much of the remaining time of the first half but were unable to add to their three point lead by half-time.

The early part of the second half was very much like the first with Guy's doing most of the attacking. Guy's were soon awarded a penalty in mid-field for a scrum infringement from which Elliott narrowly failed to score with the kick. Guy's continued to press and were rewarded with a fine try by Morgan, who kicked through past the full-back and scored in the corner. Elliott just failed with the kick.

Now, with Guy's leading 6—0 and very much on top, everyone expected them to press home their superiority. This was not to be as Guy's play became lethargic and disjointed, particularly among the forwards; because of this, Old Askeans came more in the game, and through sheer persistence scored a try which should never have been. Elliott, standing on his "25" line, for once dropped an easy high ball; the ball was hacked on by the oppositions forwards, but Brown, covering his full-back, collected the ball on or about his own line and tried to kick for touch only to screw the ball over his own line where one of the opposition dived on the ball for a try. The attempted conversion was wide.

This try should have brought back a sense of urgency to the Guy's side, but not a bit of it. They continued to play without sufficient enthusiasm and without cohesion for much of the remaining time, and although Morgan nearly scored again in the corner after a fine run Guy's play became scrappy quite sometime before the end. Elliott, having missed an easy penalty, dropped a very fine goal from a mark to complete the scoring.

Of the newcomers to the side, Osbourne stood out and brought a decisiveness to the centre which has been long wanted.

So at the fourth attempt Guy's have at last defeated Old Askeans. However, Guy's perpormance left a lot to be desired, particularly in the second half. To slacken off with a lead of only six points is ridiculous—the same thing happened last year with a lead of nine points and Guy's were held to a draw. This year Guy's held on to win, but Guy's should have pressed home their advantage in the second half and won far more easily.

Guy's: D. R. Elliott; J. R. M. Ross, R. J. Beacham, D. J. Osbourne, I. J. Morgan; B. J. Rowlands, P. G. F. Swift (Capt.), J. E. Davies, G. B. Hey, R. Hughes, J. M. Cockburn, C. G. Neville, H. C. Sharp, K. Brown, D. A. Curzon.

GUY'S v. BLACKHEATH

At Blackheath

Result: lost 0—8

Both sides had let it be known they were out to improve on last year's 11—11 draw. As it turned out, Blackheath were the ones to carry out their threat. This they did largely because of the dominance achieved by their much heavier pack in the tight play. In the set scrums they took more than eight against the head and in the lineouts only Kingdon, with some magnificent leaps offered any challenge. In the loose, however, the Guy's pack played with great fire and more than held their own. Here again Kingdon was occasionally conspicuous, and L. H. Burry, playing his first game for Guy's in place of the injured Lewis, did useful deeds when steam would allow: but the best forward on the field was, without doubt, Curzon.

Guy's threequarters had to spend most of the afternoon defending and this they did sufficiently well to limit the score to two rather unorthodox tries. Perhaps if they had come up faster and produced more vigorous tackling then counter attacks might have developed. Of the backs both the halves and Ross had good games, and Elliott mixed good touch-kicking and tackling with hesitant fielding.

Blackheath kicked off and proceeded to spend the first twenty minutes in Guy's half. An early kick at goal by Stevens hit the cross-bar and was cleared by Swift, but Blackheath were soon back on the attack and looked certain of scoring when Mahon steered through a gap in the centre only to be stopped on the line by a superb tackle by Rowlands. This was followed by a set scrum close to the line: the ball popped out of the scrum awkwardly whereupon Clarke kicked it hopefully towards his centres—the ball bounced badly for Lewis and well for Bending who went over from over half way out for a try which Stevens converted.

After this Blackheath seemed to loose their urgency, but still looked dangerous on occasions. By the end of the first half play was much more even, and it continued this way in the second half. After twenty minutes Clarke was forced to retire with an eye injury and Stevens reverted to his old position to fill the gap. Shortly afterwards Blackheath went further ahead when Thorne rounded Morgan and kicked over Elliott for Mahon to touch down. The touch judge, having at first decided that Thorne had put a foot out of play, subsequently countered the move worthy of a try. Stevens failed to convert.

The rest of play was fairly undistinguished except for one or two incidents. Ross made a couple of well-timed tackles on Bending, both of which stopped probable tries. Byrne had a good run of fifty yards before being stopped by Elliott: and Cockburn and Morgan both raised their supporters hopes briefly when they had good runs, but it wasn't really on. It had been a sunny afternoon.

Guy's: D. R. Elliott; J. R. M. Ross, D. G. Lewis, R. J. Beacham, I. J. Morgan; B. J. Rowlands, P. G. F. Swift (Capt.); J. E. Davies, G. B. Hey, H. Barry, A. J. Kingdon, C. G. Neville, H. C. Sharp, D. A. Curzon, J. M. Cockburn.

Blackheath: D. T. Stevens; P. J. Thorne, W. A. Bending, B. P. Mahon, I. L. B. Exeter; P. L. Byrne, S. J. S. Clarke (Capt.); J. Turner, P. L. Ostling, A. L. Horton, P. T. C. King, M. C. Meikle, L. B. Bailey, A. M. Hunt, M. Beckwith.

C. W. THORBURN

FOOTBALL

As at the beginning of last season the Soccer club cannot boast any decisive victories. Instead both teams have suffered heavy defeats

in matches against Old Brentwoodians, Brighton Grammar School, and Lancing Old Boys. The only other match resulted in a 1—1 draw against Westminster School.

However, we feel that with greater fitness, more co-ordination in the football, and by the contribution of some Freshmen, we can repeat the success of last season. The Hospital can and will do better.

GUY'S v. BRIGHTON AND HOVE GRAMMAR SCHOOL

At Brighton 8th October, 1966

Result: lost 6—1

Guy's visited Brighton for the first official fixture of the season.

The game ran true to form and the Hospital was well beaten by a fitter team, playing superior, intelligent, football. The only commendable performance in the Guy's side was that of Wood in goal, who played a superb game despite a quick tiring defence. Elias scored the consolation goal with a fine ground shot.

The sun again shone with uncanny dependence giving a sultry atmosphere, greatly increasing the water loss of all the Guy's players. A few members of the team remained behind after the match and were reported as having a "few words" with Mr. Wilson.

Perhaps two salient points arose from the game. Firstly, all the Guy's players arrived in ample time to catch the train, and secondly, everyone declared they would become fitter.

Team: J. Wood; R. Davy, S. Watt-Smith; S. Poole, I. Nash (Capt.), R. Lovill; T. Dutta, D. Lindridge, D. Ward, E. Elias, D. Jacobs.

I. T. NASH

GUY'S v. LANCING OLD BOYS

At H.O.P. 8th October, 1966

Result: lost 9—0

As the scoreline suggests the Hospital were more than well beaten, although playing occasional better football than in the previous match. This was due to a complete breakdown in the marking system, and an apathetic attitude of most of the team. Exceptions to the latter were the full-backs, playing their first hospital game, and Lindridge who played with ceaseless effort and was the only constructive forward. Carter had a great game in goal, but failed to prevent Poole becoming Guy's top marksman when he scored his second o.g. with a thunderbolt!

Team: M. Carter; P. Epps, K. Taylor; S. Poole, I. Nash, S. Watt-Smith; T. Dutta, D. Lindridge, D. Ward, D. Jacobs, J. Allen.

I. T. NASH

HOCKEY

GUY'S v. SOUTH SAXONS

At H.O.P. Saturday, October 8th, 1966

Result: lost 0—1

After the Freshers' trial, held on Wednesday, Guy's took the pitch with a side containing three Freshmen, and only one player in the same position as in last season's XI. The three Freshmen—D. Crafts, at left-back, and McMichen and Owen at inside forward—all had promising debuts.

Unfortunately, one of the basic faults of last season—inability to put the ball into the net—was again apparent. This was a match Guy's should most certainly have won; from the point of view of hockey ability, Guy's were several goals ahead.

The game started off at a fast pace, with Guy's creating three clear-cut chances in the first ten minutes. All were unaccepted, and this pattern continued throughout the first half —Guy's well on top, but failing to translate their superiority into goals. For the first quarter of an hour of the second half, play was centred almost entirely around Saxons' goal. During this period, two shots were cleared off the line with the goalkeeper beaten, and he even managed to save a penalty-flick. Then, completely against the run of play, South Saxons scored when their centre-forward swept a right-wing centre first time into the net. This encouraged the South Saxons, who began to have more of the game, but the match ended as it began, with the Saxons goal living dangerously—the one time that Guy's did score, Owen was penalized for sticks.

Apart from the lack of punch in the forward-line, a good performance. The defence played especially well—in fact, White only had one direct shot to save in the whole game—with the Crafts brothers and Velecott outstanding. However, as the team now knows, it's goals that count.

Team: N. White; M. Velecott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; D. Steer, H. McMichen, M. Appleby, T. Owen, S. Cripps.

M. I. APPLEBY

SQUASH CLUB

Prospects for the coming season are rather difficult to define at the moment, as there are so many unknown factors.

We shall be playing in the 3rd Division of the Cumberland Cup again after a lapse of two years in the 4th Division, and it must be one of the main aims of the season to maintain this position. This will not be at all easy as a number of the other teams are from the top clubs in London. Another imponderable factor is the standard of the "fresher" intake; here it seems as if we may have been fairly fortunate in having one or two players experienced in school squash; however, there is a considerable gulf between this and club squash.

Of the things that are certain, we know that we have all the players who helped to gain us promotion last year, and that we have a reasonably good draw in the Hospitals' Cup—having to beat The London for a semi-final place against "Tommies". The Sussex tour which was such a success last year is being continued; it is only hoped that "Thatchings" will be open again, as its excellent hospitality contributed so much last year.

In summary, it can be said that the unknown strength of the opposition in the Cumberland Cup is going to make the season a very interesting one—and we are hoping, successful.

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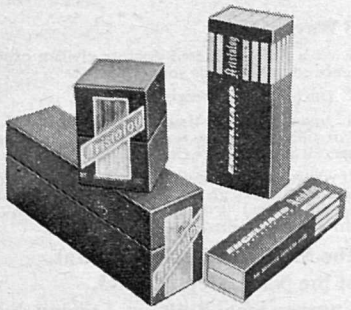

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3 Ways of Entry

1. As a fully registered doctor; civilian experience counts towards your seniority.

2. During your pre-registration year.

3. As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

If you would like more information, write to the address below, giving details of your age and qualifications. A personal interview can be arranged if desired.

The Medical Director-General of the Navy, Dept. 26FR3, Empress State Building, London, S.W.6

Royal Navy

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL
December 1st, 1966

Applications are invited for the following house appointments due to begin on December 1st, 1966; applications giving choice of post and choice of hospital, in order of preference, to be lodged with the Superintendent, not later than **October 28th, 1966.**

House Surgeons *(formerly Assistant House Surgeons)* 2
House Physicians (formerly Assistant House Physicians) 3
Throat and Ear House Surgeon 1
Orthopaedic House Surgeon 1
Genito-Urinary House Surgeon 1
Thoracic House Surgeon 1
Children's House Physician 1

The above appointments will be for six months and will be open only to pre-registration candidates applying for their first appointments and not to candidates seeking their second six months appointment.

House Surgeons 2
House Surgeon to the Surgical Unit .. 1
House Physicians 3

The above appointments will be for six *months and will be open to pre-registration* candidates applying for their second six months appointment.

Casualty Officers
(Post-registration) 3
Resident Obstetrician
(Post-registration) 1
House Physician in Clinical Pathology
(S.H.O.) 1
R.M.O.s in Nuffield House
(S.H.O.) 2
1 = 1.12.66
1 = 1. 1.67.
Resident Anaesthetists
(S.H.O.) 2
Children's House Physicians at the Evelina Hospital
(Post-registration) 2
1 = 1.12.66.
1 = 1. 2.67.

ST. OLAVE'S HOSPITAL

House Physicians
Pre-registration 2
House Surgeon
Pre-registration 1
House Physician
S.H.O. 1
House Surgeon
S.H.O. 1

NEW CROSS HOSPITAL

House Physician in General Medicine
(S.H.O.) 1
House Physician in General Medicine
(Pre-registration) 1
Orthopaedic House Surgeon
(S.H.O.) 1
Orthopaedic House Surgeon
(Pre-registration) 1

JOYCE GREEN HOSPITAL

House Physicians 3
Pre-registration
2 to commence 1.1.67
1 to commence 1.2.67

LEWISHAM HOSPITAL

House Physician to Dr. Roberts
Pre-registration 1

ORPINGTON HOSPITAL

House Surgeon with Gynaecology
Pre-registration 1
House Surgeon with Orthopaedics
Pre-registration 1

PEMBURY HOSPITAL

House Surgeon
Pre-registration 1

ST. JOHN'S HOSPITAL, LEWISHAM

House Surgeon with Gynaecology
Pre-registration 1
House Surgeon with Gynaecology and Orthopaedics
Pre-registration 1
To commence 1.1.67

ST. NICHOLAS' HOSPITAL

Houe Physician to Dr. Scott
Pre-registration 1

NOTICE FOR PRE-REGISTRATION CANDIDATES

Pre-registration candidates are reminded that the number of posts at Guy's is small compared with the number of students who are likely to qualify. Students applying at Guy's therefore, are advised to consider applying for pre-registration posts elsewhere at the same time, in order to avoid delay in obtaining a post. A number of recognised posts are available in the South-East Region. Details of posts in this region and elsewhere in the country are available in the Medical School Office.

Pre-registration candidates who have completed six months in Medical or Surgical posts are reminded that they must now apply for Surgical and Medical posts respectiveiy. A candidate who has completed his first six months in a speciality (Surgical or Medical) may not do another six months in a specialty, but must seek a post in general medicine or general surgery as the case may be, according to G.M.C. regulations.

R. J. CANN,
Acting Superintendent

October 3rd, 1966

PASS LIST

UNIVERSITY OF LONDON

M.D.S.

D. J. Neill

Ph.D. (Medicine)

J. K. Luffingham — Judith B. Senior

Ph.D. (Science)

Margaret W. Aaron — A. B. Wells

M.Sc. (Radiation biology)

R. A. Lusty — J. C. Lynn
A. R. Richards — M. N. Richardson

B.Sc. Special Examination

Anatomy

2nd Class honours (Upper division)

D. J. Jolley — R. H. Salt
W. J. Owen

2nd Class honours (Lower division)

P. Hall — J. G. Proud
M. J. James

Physiology

1st class honours

G. R. Barker

2nd Class honours (Upper division)

G. Mc.L. Cochrane — G. A. Corbett
J. F. Dufton — Susan V. Kempe-Roberts

1st M.B., B.S.

R. D. Barough — D. MacDairmid
Margaret E. Cartwright — R. G. Speight

G.C.E. Candidates qualifying for exemption

Elaine V. G. Abbey	S. D. Horsley
Linda J. Addison	P. R. Hunt
M. F. Ashley	Alison Ironside
P. E. Bennett	R. J. Lane
S. E. T. Bowden	R. V. Leeburn
F. D. K. Chan	P. J. M. Moulder
P. K. Coates	Susan Parry
J. S. Cowling	Mary D. Powell-Cullingford
J. P. Dine	J. A. G. Punt
Rosalind C. S. Dow	A. M. Ross
A. M. Evans	Felicity J. Street
H. K. C. Fan-Lun	D. V. P. Thomas
H. Greenway	Joanne C. Timmis
P. R. Harrison	G. R. Waterhouse
Gillian L. Hoare	
Frances E. Hogwood	

PAPERS BY GUY'S MEN

Abrams, M. E. Simulation of the mechanical properties of the lung. *Proc. R. Soc. Med.*, 1966, **59**, 783.

Adams, C. W. M. Cholesterol and atherosclerosis. *Med. News*, 1966, Sept. 23, p. 10.

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ENTRY OF STUDENTS

October, 1966

MEDICAL SCHOOL

First M.B. Students

Name	School
Barker, G. L.	Ilford County High School
Crawford, A. D.	Culford School, Bury St. Edmunds
Dawson, Dorothy M.	Manchester High School for Girls
Epsom, M.	St. Augustine's Abbey School, Ramsgate
Griffith, Fiona M.	Hinchley Wood School
Hampson, Lynne K.	Watford Technical High School
Jerichower, D. L.	Westminster City School
Kelleher, D. I. F.	Sutton Valence
Klosok, J. K.	Cardinal Vaughan School, London, W.14.
Little, Avril	Girls' Grammar School, Gateshead
McMichen, H. U. S.	Cheltenham College
Manning C.	Tonbridge School
Ng, Tang Fui	College due St. Esprit, Mauritius
Norwell, N. P.	Salesian College
Parkin, D. H.	Queen Elizabeth's Grammar School, Horncastle
Powell, M. P.	The King's School, Canterbury
Price, D. C. J.	Charterhouse
Pobertson-Ritchie, H.	Midhurst Grammar School
Taylor, J. C.	Reed's School, Cobham

Second M.B. Students

Attwood, A. I.	Hastings Grammar School

Baker, C. C.	Alleyn's School, Dulwich
Bateman, D. N.	Queen Elizabeth's Grammar School, Blackburn
Barry, R. M.	Ampleforth
Batch, A. J. G.	City of Norwich School
Bax, N. D. S.	The King's School, Worcester
Bennett, C. J.	Sudbury Grammar School
Betteridge, D. J.	Boy's Grammar School, Ashby-de-la-Zouch
Brain, A. J. L.	Dean Close School, Cheltenham
Brain, Penelope	Sherborne School for Girls
Cann, Margaret L.	Notting Hill & Ealing High School
Cardell, P. J. S.	The Oratory School, Nr. Reading
Coles, S. R. D.	Epsom
Cormac, Irene D.	Christ's Hospital Girls' High School, Lincoln
Darling, R. M.	Monkton Combe School
Delamere, J. P.	The Grammar School, Ulverston
Dick, B. G. A.	Clifton
Downing, D.	St. Edmund's College, Herts
Dunbar, G. C.	Heversham Grammar School, Kendal
Edmonds, W.	Epsom
Evans, P. R.	Shene County Grammar School, S.W.14.
Fenn, A.	Bishop Auckland Grammar School, Co. Durham
Garnons Williams, Annabella	Berkhamsted School for Girls
Godsmark, Angela W.	Lymm Grammar School, Cheshire
Hammond, S. R.	Haileybury & I.S.C.
Hanley, J. G.	Stowe
Harrild, J. N.	Sevenoaks School
Hewlitt, J. L.	Collyer's School, Horsham
Hunt, D. M.	Radley
Hyde, K. R.	Kingston Grammar School
James, G.	Llandysul Grammar School, Cardiganshire
Jones, N.	Epsom
Knox, Jean M.	Cheltenham Ladies' College
Koeller, Joanna A.	Heathfield
Lalani, A. V. A.	Sevenoaks
Lange, Sarah	South Hampstead High School
Leader, J. R. H.	Northgate Grammar School for Boys, Ipswich
Lee, Doreen	St. Francis College, Letchworth
Light, A. M.	Peter Symonds School, Winchester
Logan, C.	Leighton Park
Mackay, R.	Sedbergh School
Mansell, M. A.	The Haberdashers' Aske's School, Herts.
Mackenzie, J. K.	King Edward's School, Birmingham
Marks, N. J.	Cranleigh School
Martindale, B. V.	Caterham School, Surrey
Masser, M. R.	Penistone Grammar School, Penistone
Matthews, P.	King's College Grammar School, Cardiff
Mendis, T. De F	St. Thomas's College, Ceylon
Munir-Ahmed, Mahnaz	Convent of Notre Dame, Cobham
Nielsen, M. S.	Brighton College
O'Keefe, S. J.	St. George's College, Salisbury, Rhodesia
Parsons, A. D.	West Buckland School, Barnstaple
Peters, G.	Hendon Grammar School
Price, M. L. D.	St. Brendan's College, Bristol
Pryor, G. L.	Newquay Grammar School, Cornwall
Reynolds, J. H.	Nantyglo Grammar School, Mon.
Ribet, P. W.	Beaumont College
Rickerby, Anne	Grammar School for Girls, Maidstone
Rowland, C. G.	Chepstow Grammar School, Mon.
Rudge, C. J.	Woodhouse Grove School, Bradford
Salter, Loretta	Camden School for Girls, London
Sargent, J.	Sherborne
Scourfield, A. J.	Rhondda County Grammar School for Boys
Shellim, A. J.	Mill Hill School
Side, C. D.	Ashlyns School, Berkhamsted
Smythe, P. J.	Shrewsbury
Stanley, R. S.	Solihull School
Starke, I. D. St.B.	Alderham
Taylor, G. C.	Wyncliffe College, Glos.
Taylor, Pamela J.	Merchant Taylor's Girls' School, Liverpool
Thomas, C. J.	St. Dunstan's College
Thomson, R. G.	Dulwich
Thorburn, Rosalind	Arnold High School for Girls, Blackpool
Thornington, M. J.	The Grammar School, Maidstone
Valentine, A. R.	Wyggeston Boys' Grammar School, Leicester
Van Essen, Morna	Queenswood
Vincent, Valerie	Slough High School
Wass, J. A. H.	Rugby
Ward, R. D.	Godalming County Grammar School
Williams, D. R.	The Bishop Gore Grammar School, Swansea
Wright, R. W.	Charterhouse

Combined Course

Avery, B. S.	Abingdon School and Guy's Hospital Dental School
Cheney, G. T.	Brighton, Hove & Sussex Grammar School and Guy's Hospital Dental School
McAndrew, P.	Epsom and Guy's Hospital Dental School
Quant, J. A.	Eltham College and Guy's Hospital Dental School
Storrs, T. J.	King Edward VI Grammar School, Lichfield, and Guy's Hospital Dental School

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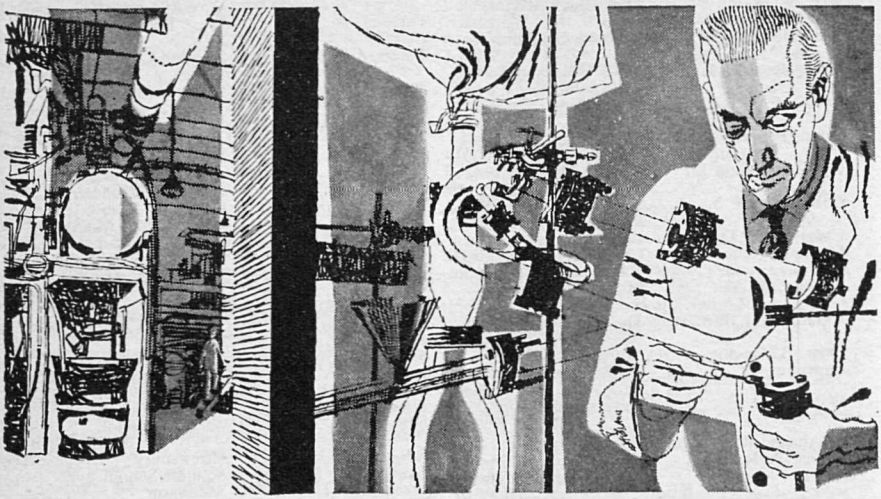

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Clinical Students

Bingham, J. B.	Northgate Grammar School and Clare College, Cambridge
Bushell, T. E. C.	Stowe and St. John's, Cambridge
Chalmers, A. H.	Lancing and Queens, Cambridge
Clarke, C. R. A.	Rugby and Gonville and Caius, Cambridge
Clyma, Elizabeth A.	St. Austell County Grammar School and Girton, Cambridge
Coulson, A. S.	Hendon County School and Queens, Cambridge
Davies, T. H. P.	Newport High School and Christ Church, Oxford
Fortune, M. J.	Whitgift School and Gonville and Caius, Cambridge
Hudson, P.McK.	Radley and Emmanuel, Cambridge
Hughes, D. C. C.	Marlborough and Clare, Cambridge
Morris, I. M.	Royal Grammar School, Newcastle-on-Tyne, and Selwyn, Cambridge
Osborn, J. D.	Harrow and Emmanuel, Cambridge
Pounder, R. E.	Eltham College and Peterhouse, Cambridge
Price, J. F.	Dulwich and St. John's, Cambridge
Salter, E. J.	King's School, Cambridge, and Sidney Sussex College, Cambridge
Scott, I. H. K.	Liverpool College, and Gonville and Caius, Cambridge
Sherwood, W. G.	Queen Elizabeth Grammar School for Boys', Carmarthen, and Gonville and Caius, Cambridge
Spurlock, Christine J.	Lady Margaret High School, Cardiff, and St. Andrew's High School, Kingston, Jamaica. University of the West Indies
Summers, Lucy J.	Channing School, Highgate, and New Hall, Cambridge
Sweny, P.	The John Fisher School, Purley, and Downing College, Cambridge
West, C. G. H.	Whitgift School and Corpus Christi, Cambridge

DENTAL SCHOOL

October, 1966

First Year B.D.S. Students

Barker, Gillian M.	Prince Henry's Grammar School, Evesham
Bazlinton, S. C.	Buckhurst Hill County High School, Chigwell
Butcher, C. W.	Worth
Collier, Hadel L.	Eltham Hill School
Combeer, Anne	Roedean
Davies, D. W. S.	The College, Llandovery
Evans, Dorothy R.	St. David's County Secondary School, Pembs.
Fallowfield, A. G.	Worthing High School for Boys
Gould, T. R. L.	Merrywood Grammar School for Boys, Bristol
Gross, M. D.	Quintin School, London, N.W.8.
Harland, E. T.	Giggleswick School, Settle
Hathorn, W. H. G.	St. Paul's
Hughes, M. J.	Framlingham College, Suffolk
Jeeves, O. L.	Bramcote Hills Grammar School, Nottinghamshire
Kelly, A. C.	St. Benedict's Senior School, Ealing
Kinghorn, A. G.	Epsom
Knowles, R. C.	Westminster
Sanders, R. J. H.	Monkton Combe School
Stanley, Rosemary J.	Howell's School, Cardiff
Theaker, F. S. G.	Queen's College, Taunton
Wakeham, J. Y.	Cray Valley Technical School, Sidcup

Second Year B.D.S. Students

Adams, P. N.	Reigate Grammar School
Bailey, B. M. W.	King Edward VII Grammar School, Coalville, Leics.
Ballard, C. H.	Reigate Grammar School
Beckerson, J. C.	Rye Grammar School, Sussex
Briggs, D. K.	Spring Grove Grammar School, Hounslow
Carter, M. J.	Dudley Grammar School, Worcs.
Clare, C. J.	Adam's Grammar School, Newport, Salop
Cope, J. A.	Bishop Vesey's Grammar School, Sutton Coldfield
Crafts, D. R.	Mill Hill
Croft, R. C.	St. Bees, Cumberland
Curtis, J. L.	Selhurst Grammar School for Boys, Croydon
Drage, S. A.	Henry Mellish Grammar School, Bulwell, Notts.
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Langly-Smith, G. F.	The King's School, Canterbury
Law, Mary	Ely High School for Girls
Learner, I. H.	Monkton Combe School
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BIRTHS

McCOLL.—On the 9th October, 1966, to Jean (née McNair) and Ian McColl, a daughter, Mary Alison, a sister for Alastair and Caroline.

SHAW.—On August 16th, 1966, at the Simpson Memorial Maternity Pavilion, Edinburgh, to James and Anne Shaw (née Campell, S.R.N., S.R.M.) a daughter.

MARRIAGES

FORTESCUE—HOLLINGHURST.—On 24th September, 1966, at St. Bartholomew's Church, Hyde, Winchester. Major Frank Fortescue to Doreen Hollinghurst.

KNOWLES—HERBERT.—On September 3rd, at Southwell Minster, James Knowles, M.B., B.Chir., to Joy Herbert, S.R.N., S.C.M.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

EDITORS	M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT	G. E. RATCLIFFE
NURSING CORRESPONDENT	E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2041

PASSIM

And they continue to controverse,

"East is East, and West is West,
And never the twain shall meet."

Rudyard Kipling

. . . . . But there are many who will grow larger as a result of the difference.

Mass and esoteric media pound their supporting victims with recurrent and reverberating controversies, impassioned and pseudo-rational. The US spectacle of Brook v. Honey on recent television, the equally recent resounding of disagreement between the ancient professions of medicine and the law, and the more local beery battle of words over South Africa, the Cricket Club and the minority student behaviour in the East Wing have all titillated, annoyed and exercised the nodding of sage heads. Many observers slipped rapidly into the opposing camps and just as rapidly became blind to the occasional truths of the opposition. There was a demonstration of a shrinking logic—A saw all, B saw all, but when put together, they saw less than all.

Inevitably the voice of imagined maturity of thought rises up to suggest gently or otherwise that the controversy should never have been publicized in the first place, that all manner of debasement and harm has occurred in relation to all manner of sacred cows, and that the show has been a futile exercise in notoriety. "It is sounder to ignore than notice" we are asssured. Immediately we can agree that much irrelevant nonsense is spewed forth, but equally the punctuation of sheer sense is often as obvious. The true-blue emotionally-unemotional recalcitrance of tradition is pushed in its deified obesity to smother the new thought, as it must. The protagonist and antagonist suddenly cease to hear each other, as they must. And nevertheless out of this incompatibility is born the child of further knowledge and with luck understanding.

The legal and medical professions have now added a stamp of respectability on this spectacle of two sides irreconcilable from the start. The indignant remarks of both on the conduct and attitude (sic) of each other in the recent bench admonishment of a psychiatrist have revealed, if they ever concealed, how impassioned ignorance is not the private realm of the tabloid. Yet those who have

witnessed that spectacle have learnt a little more of the attitudes of each and of their relationship with each other. They have also learnt more of the situations within which those two professions operate, and inevitably they will be changed to some degree, however small, by the experience.

That such controversies should be recorded in a manner which allows them to be seen again at a later date is of further importance especially to the combatants. While the basic antipathy is unlikely to be changed, their appreciation of the actual situation in which they sweat out their grotesque obsession in shouting down each other may improve, and with luck the situation may be aided, if not in solution, then at least in more accurate definition.

Thus we not merely defend but would encourage the publication of controversy. With the recognition that those who loudest oppose such publication are those the controversy has found as homing targets, we hope to have suggested that there is a larger issue at hand than the individual points of view. It is an issue that refuses to co-exist with prejudice.

Footnote: We eagerly await the results of the customary inventive prostitution of the above by the cheaper (sick) newspapers.

We would like to extend our congratulations to Mr. J. C. Gazet upon his appointment to the staff of St. George's Hospital.

GUY'S DIARY

OCTOBER

31st	M.	1.00	Clinical lecture. "The Foetal Attitude". Mr. GIBBERD.
31st	Mon.	8.30	Inflam No. 2 (Halloween Party) will take place in the Students' Club Bar, from 8.30 p.m. till 2 a.m.

NOVEMBER

1st	Tu.	1.00	Clinical lecture. Mr. ECKHOFF. "Nasal Deformities".
		5.00	"The Adult under Treatment" and "Them and Us". Films in the Anatomy Theatre.
7th	M.	1.00	Clinical lecture. Dr. BAKER. "Cardiomyopathy apart from Coronary Artery Disease".
11th	F.	1.00	Clinical lecture. Prof. BUTTERFIELD.
17th	Th.	5.00	Neurosurgical Round : In the Clinical Theatre. Conducted by Mr. MURRAY FALCONER.
26th	Sat.	10.00	Clinico-Pathological Meeting : In the Clinical Theatre. Exhibition : Urethral catheters (in Gordon Museum).

RESUSCITATION OF THE NEWBORN

A Note About Resuscitation of the Newborn in the Nineteenth Century with Special Reference to Haighton and Blundell at Guy's Hospital

by

E. A. Williams

Consultant Obstetrician and Gynaecologist, the United Oxford Hospitals.

When in early civilization syncope and cardiac arrest occurred, producing a death-like state, it must sometimes have happened that agitated or planned attempts would be made to breathe into the victim and to move his limbs. Sometimes oxygenation, and circulation of the blood would be achieved and the victim would live again. A prophet performing such an act was held to have breathed into the dead man the spirit of the Holy Ghost. Surely it was in this way that Elisha restored the child of the Shunamite?

The ancient Egyptians may have used a reed to insufflate air in reviving asphyxiated persons, but modern understanding of the processes had to await on Harvey's discovery of the circulation of the blood, and on Priestley's demonstration of the life sustaining properties of atmospheric oxygen. From this point forward it was inevitable that clinicians would become involved in seeking ways to resuscitate efficiently and to construct the necessary apparatus.

Lozes, in his essay on Asphyxia in the New Born (1818), recorded that the 17th century Roman physician, Panarole, when dealing with asphyxia neonatorum, used bellows to blow air into the infant's mouth, thereby hoping to cause air to enter the lungs. The method was claimed to be of value, but drawbacks were that air was often forced into the stomach in excessive amounts; this sometimes lead to impaired action of the diaphragm. Moreover, it did not always cause expansion of the lungs, for the airways were sometimes obstructed by "sticky mucus and the lung tissue remained compact". It was believed that tracheostomy would provide a more effective method of introducing air through a tube. Although it may have been attempted on some occasions, it had obvious disadvantages. Lozes wrote: "is it not evident that air blown in by a tube will go up and escape by the glottis? Furthermore, the operation of tracheostomy can be difficult on the new-born, and sucking may be hindered before there was healing of the scar."

Lozes revealed that in about the year 1780 the French physician, Chaussier of Grenoble invented a laryngeal tube made of metal some 18 cms. long. "It resembles a bladder sound, a little flattened at the sides, so that it does not wobble between the fingers, and thus to fit more easily the oblong aperture of the glottis. Its broad end is sufficiently rounded to receive the end of a bellows or to put into someone's mouth. The other end smaller, flattened and which must enter the larynx is perforated on its sides with two oblong holes. At 36 mms. above the small extremity is placed a washer which serves to fix a sponge, thus the opening of the larynx is completely closed and insufflated air must necessarily dilate the lungs. It is easy to use, and made to enter the larynx by slightly flexing the infant's head on the neck, using the left index finger on the tongue, then depressing the base of the tongue, while the thumb and middle fingers press on and hold the larynx. Once the tube enters the larynx the body of the instrument is pressed so that the sponge is pushed into the circumference of the glottis. The broad end is placed in the mouth, any mucus is aspirated from the bronchi and air is puffed gently at intervals."

Chaussier had thought that it was good to use expiratory air, because of its warmth and moisture. "Better not to use a household bellows, for dust and ash must thereby be carried into the lungs, but air supplied from a simple reservoir was in all respects satisfactory, although the apparatus was not easily available except with forward preparation." Chaussier described and illustrated a suitable apparatus.

Lozes made many interesting observations, quoting extensively from Chaussier's work. He described one or two interesting clinical cases. For example, in 1743, a M. Rigaudeaux, assistant surgeon at the Military Hospital, Douai, was called to deliver a woman at 5 a.m. but could not arrive until 8.30 a.m. The woman had been dead for two hours and was already in her shroud. M. Rigaudeaux removed the shroud and found no sign of life. Following an impulse he put his hand into the uterus and, finding the orifice well dilated and the bag of waters intact, he turned the infant and delivered it by the feet. He gave it to the women present ,and told them each in turn to blow into the child's mouth. The women worked willingly and carefully. After three hours the infant opened its mouth and within a quarter of an hour was crying lustily. There is no doubt, that in the late 18th century in medical circles resuscitation of the newborn was a subject of interest and that it evoked a very considerable discussion.

In the early 19th century, resuscitation of the newborn was a matter of great interest at Guy's Hospital. It is pleasing to learn that Haighton, a physiologist, and the first appointed obstetrician, advocated methods which at first were well received. Later they were set aside, indeed forgotten, but in present times they have been rediscovered and considered of great importance.

In 1816 the lecture notes of John Haighton were recorded by Waddington in manuscript. Haighton was quite explicit in his instructions to students concerning babes born and persisting in a

state of "torpor". "Frequently, torpor could be overcome by stimulating means, but most effectual was artificial respiration," and according to Haighton there were three ways of performing this.

"Firstly, by blowing air into the mouth, having ascertained that the rimma glottis is open, this to be detected by the forefinger of the left hand. You should blow into the mouth and make gentle pressure on the chest alternatively—you prevent air from passing into the stomach by pressing the larynx backwards at the same time as you inflate the lungs.

"The second is by pressing the sternum and ribs towards the spine, then withdrawing the hand. Recollect, however, that the ribs are easily broken, for they are exceedingly tender.

"The third and most effectual mode is by means of the tracheal pipe. The head of the child should be placed a little back. The forefinger of the left hand should touch the epiglottis. You introduce the pipe into the oesophagus, then bringing it forward by means of the finger, you alternatively inflate the lungs and make pressure on the chest. This process ought to be continued for a considerable time if you perceive the least sign of life."

Haighton was succeeded by his nephew James Blundell, who used the title and style of Professor of Obstetricy at Guy's Hospital. Blundell's appointment was indeed a happy example of nepotism, for in his short professional life at Guy's Hospital, he had the distinction of being the first man in England to perform vaginal hysterectomy. He was also the first man to remove the uterus for cancer. Furthermore, Blundell was distinguished for his experiments in blood transfusion and is believed to be the first man to have successfully transfused blood from one human being to another. Keynes has written: "Blundell established so many fundamental points, that it is difficult to exaggerate the importance of his work in the history of blood transfusion."

James Blundell's lectures to students were edited and published by his friend, Thomas Castle, M.D. (1834), and this textbook, for such it is, is clearly the first inspired by a member of the obstetric staff of Guy's Hospital. Naturally, Blundell was influenced by the principles and techniques that Haighton had established, and in preferring artificial respiration with a tracheal pipe, he gave a very exact account of the procedure.

"The tracheal pipe is a little pipe of silver, designed to pass into the trachea, its end closed like a catheter with a long, broad fissure on either side to give free vent to air and mucus. The closed end with lateral openings I prefer as there is less risk of injuring the delicate membrane of the trachea if a terminal aperture does not exist.

"In introducing this instrument there is some difficulty at first if you do not manœuvre rightly. Yet every movement is of the greatest importance, for while you are blundering the child is dying. My method of operating is as follows:—

I pass the forefinger of my left hand down upon the tongue, and into the rimma glottis, and then, using the tube with my right hand,

I slide it along the surface of the finger till reaching the rimma glottis, I insert the tube at the moment the finger is withdrawn from it, afterwards feeling on the front of the neck whether the instrument is lying in the trachea or the oesophagus. From your own lungs inflate the lungs of the foetus. Five and twenty respirations there ought to be in a minute, the newborn child breathing faster than an adult. You may ask me perhaps whether it would not be better to use bellows? Make the experiment and you will not repeat the question.

When you have made the artificial respiration for a few minutes you make your observations on the child. Feel the chord—you will sometimes have the satisfaction to find it pulsate. Feel at the root of the funis close to the abdomen—you sometimes feel it there when at the distance of an inch it cannot be perceived. Observe the face, perhaps you find the cheeks reddening, the countenance forming and the lips quivering. When these marks of returning life are observed pause a little . . . then frequently the child will make a spontaneous effort of respiration. A deep sigh is the first breath it draws, and in twenty or thirty seconds it breathes again." Blundell described the need to observe further and to assist or not according to the child's need.

Blundell seemingly regarded the tracheal tube as a new development or invention attributable to Haighton. Indeed, there can be little doubt of Haighton's originality at Guy's, but it is perhaps unprofitable to conjecture overmuch regarding claims for absolute originality. There is reason to think that this important contribution from Guy's Hospital regarding the use of a tracheal pipe in resuscitating the asphyxiated newborn, was widely known in the early 19th century.

Nevertheless, the method fell into disuse and was largely, perhaps entirely, forgotten by the latter half of the century, and the tracheal pipe was discarded. Curiously it has not been identified in any collection of historical surgical instruments—perhaps it was mistakenly considered to be some form of bladder catheter. It is likely that the tracheal pipe was abandoned because it was not used with the delicacy and skill that Blundell had advised—the rigid tube passed hastily could well have caused injury to the fauces, pharynx and air passages. Forcible inflation would have caused pneumothorax and surgical emphysema. It is almost certain that these disasters caused Galabin to advise somewhat cryptically, "Never use the tracheal pipe."

British obstetricians seemingly had no further interest in intratracheal insufflation until in 1935 general interest was restored by a decisive report from Guy's Hospital in which Blaikley and Gibberd described their method of tracheal insufflation using 95 per cent oxygen and 5 per cent carbon dioxide.

Blaikley and Gibberd used a modified pharyngoscope which enabled the larynx to be seen easily, they used silk webb endotracheal catheters Nos. 3, 4 or 5 according to the infant's size.

The oxygen-carbon dioxide mixture was delivered from a 3 litre bag; an aneroid manometer enabled the pressure of delivery to be controlled. It was advised that a pressure of 35 cms. of water in the

bag would ensure that the gases delivered into the trachea would be at a pressure of about 15 cms. of water, considered the optimum in promoting alvealor expansion. These then were the conditions necessary to promote safety in intra-tracheal insufflation, and to restore to general use a method which was foreshadowed in all but detail, more than a hundred years before in the same parent hospital.

Blaikley and Gibberd had noted that intra-tracheal insufflation could on rare occasions be disappointing—they referred to the babe "drowned in liquor amnii so that the bronchioles and even alveoli are not simply collapsed but distended by fluid"—a condition which at first sight would seem to depend simply on the inhalation of liquor in utero. But this may be an over simplification of a mechanism that could well involve transudation from the pulmonary capillaries.

It is perhaps appropriate to recall the work of Yendell Henderson (1931) in the field of neonatal asphyxia, for it served to stimulate obstetricians to fruitful interest in the anoxic neonate. Furthermore, Yendell Henderson advocated inhalations of a carbon dioxide enriched atmosphere to promote vigorous breathing, which he considered a prophyllactic against atelectasis and those pneumonic conditions which even today remain so fatal to the new born.

Yendell Henderson's theory may be largely unaccepted, but it is certainly more credible than was Akerren and Furstenburg's advocacy of intra-gastric oxygen for respiratory insufficiency. Yet this cause was espoused readily, enthused over wildly, and now sadly discarded. Obstetricians have set aside a measure of their responsibility for neonates, but together with paediatricians and respiratory physiologists they are examining the mechanisms that so marvellously accomplish the translation from foetal life in a sea of liquor to that of the infant breathing air.

It remains a most necessary accomplishment that the obstetrician should be dexterous with laryngoscope and "Tracheal Pipe".

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Acknowledgements

I am very grateful to William Hill, Esq., Librarian, The Wills Library, Guy's Hospital, for photostat copies of the Waddington manuscript, and to Dr. Megan Richards of Newport for translations of the thesis by L. H. L. Lozes.

NOTICES

Guy's Hospital Theatre Club

For the second successive year, the Theatre Club has been invited to enter the World University Theatre Festival of Nancy, in France. We feel that this is an opportunity not to be missed a second time, if only because we can represent the hospital internationally. It seems fair, therefore, that everyone in the hospital should be given the opportunity to help this venture materialise. It is for this reason that we invite any member of Guy's community to write some of the requisite material.

One section of the festival involves the performance of a 20-minute play, written by each entrant, around a set theme, which reads as follows:—

"In a past, present or future society, a young couple express by their actions, behaviour or mere existence, that they do not conform to the customs or rules (political, social, religious, moral or sexual, etc.,) of the community (country, town, university, etc.) in which they live. Considered as asocial they encounter the hostility of the group. Tension increases and finally rises to breaking point."

Although the standard of the festival will be high, especially in relation to this section, we feel certain that there is sufficient literary talent, yea, genius lying dormant in the hospital to meet the challenge.

I would appreciate and look forward to the receipt of all interpretations of this theme by December 1st, 1966, preferably typewritten and not for a large cast.

RUSSELL E. COWAN.

Art Society

The A.G.M. of the Art Society is to be held at 12.30 p.m. in the North Common Room of the East Wing on Friday, 4th November. All those interested in the future of the Society are invited to attend and will find a copy of the Agenda now pinned to the Art Society Notice Board at the entrance to the North Common Room.

The first meeting of the term will consist of a film programme, which is to be shown at 5.15 p.m. on Thursday, 3rd November, in the Clinical Lecture Theatre on the second floor of New Guy's House. The meeting should last for approximately one hour.

A Winter Exhibition is to be held in the Gordon Museum from November 21st to December 2nd, and all members of the Hospital are invited to contribute paintings, drawings, pieces of sculpture, etc. Prizes of £3, £2 and £1 are offered for the three entries considered to be of greatest merit. Entry forms and further particulars ae obtainable from the Secretary, c/o the East Wing.

Jazz Club

The Jazz Club ceased to function about a year ago. Until that time it had provided an interesting hour or two a week for the faithful few who supported it. As the Editors of the *Gazette* said in the last edition in Passim, we have fired all our guns at the freshers. The freshers have now fired a gun at us and the result has been the reformation of the Jazz Club.

At a meeting on the 13th October, a Committee was elected, consisting of:

Acting President—Bill Hughes, 2nd year Clinical.
Chairman—John Dobson, 4th year Dental.
Secretary—Anne Combeer, 1st year Dental.
Publicity Secretary—Richard Forrest, 2nd year Clinical.
Treasurer—Alan Stevens, 4th year Dental.
Librarian—Nick Hopkinson, 3rd year Dental.

We hope to gain the support of all those interested in any aspect of Jazz. The Society plans to create at Guy's a broader-minded picture of this field of music, and to this end we hope to meet once a week during the lunch-hour and to play records, hear talks by experts, and possibly to form a Jazz Group of our own.

REPORTS FROM SOCIETIES

Debating Society

The subject of the first debate of the academic year was " This house believes that Guy's should dissociate itself from U.L.U." In the chair was the Student President of the Debating Society, Mr. R. H. Savage.

The proposers, Mr. R. Davies and Mr. J. Morseman, began by flattering the Chairman and interpreting the motion as putting U.L.U. on trial for poor management and failure of its idealistic aims. They advocated more support of Guy's own societies, and resented implications that medical students need U.L.U. to make them mix with students of other faculties. Finally they warned the House that if Guy's students were the " amoral, porcine and proselytising group " referred to in the *Gazette* (1st October, 1966), it was our moral duty to leave, and thus refrain from contaminating the pure and innocent artists, engineers and other medical students at U.L.U.

The opposers, Dr. M. D'Souza and Mr. P. Briggs, began by flattering the members of the House and then reminding them of the consequences of withdrawing Guy's considerable numbers from U.L.U. They maintained that U.L.U. provided good facilities for its members, but that Guy's Social Societies were atrophying due to student apathy, and so had little to offer interested students.

Speeches from the floor were varied, and included comments like "Let's leave U.L.U. before we're thrown out", to "Blow U.L.U., I'm all right ". Welcome speeches from nurses and freshers deplored the selfish and snobbish attitude of many student speakers, and suggested " injecting new blood into U.L.U." if it were as bad as it had been made out to be. The speeches from the floor gave the impression that rather than U.L.U., it was Guy's Social Societies which were on trial: so that when the motion was defeated by 44 votes to 13 (2 abst.), one could interpret it, either that Guy's clubs had been found wanting, or that flattery pays.

M. RUTLAND (Debating Society).

CORRESPONDENCE

Sophie Crees Fund

SIR,—The Governors have approved the development of a roof garden on the top of Tabard House, where the resident domestic staff live. The Sophie Crees Fund has an unexpended balance of nearly sixty pounds. It has been suggested that this should be used for the purchase of comfortable chairs and other items for the roof garden and a small plaque would be set up, inscribed as follows:—

This garden was set up as a memorial to Sophie Crees who gave 70 years of devoted Service to Guy's Hospital and Schools.

I trust that those who subscribed to this fund will feel that this is a worthwhile use of the balance.

Yours, etc.,

J. J. CONYBEARE.

Lace for Hard-Working Dragons

SIR,—The cold blast of air mentioned in the Nursing Section of the October 1st *Gazette*, sent an icy chill down my spine.

What is so dreadful about starch and frills? Hold on to "the little white bow beneath the chin". It is very attractive and warranted to draw the admiring glance.

The lacey caps worn by those "Autocrats" of now and yester-year, make even these hard working dragons appear almost human.

As for the younger and more inexperienced members of the Nursing Staff being left more frequently in charge—has it not been said, "A ward without a Sister, is like a home without a Mother."

Yours, etc.,

DORIS CHRIMES
(ex-Autocrat).

170, Kennington Park Road,
S.E.11.

Professor Spurrell

SIR,—Just recently I went to the University of New South Wales in Sydney and was told by Professor Wendell-Smith the sad news about Professor Spurrell. I was also sent the *Gazette* by A. Hodges, who is in Brisbane. Hodges receives the *Gazette* from "Old Baker". Baker has always kept in touch with his "boys", something we shall always appreciate.

I left Guy's in January, 1953, to take up an appointment at the University of Otago, Dunedin, New Zealand, and came over to Australia, June 1959. Every year after I left Guy's I received from Dr. Spurrell at least one, sometimes two letters telling me of the Guy's new building programme, the Medical School extensions, news about Staff and other topics of interest. We had long discussions about my new countries, the geography, the vast distances travelled during holiday periods, environment, educational opportunities for my children, and lots of other things.

My first vivid memory of him was in 1929, when a lab-boy severely burnt himself around the eyes with glacial acetic acid. On his entrance to the scene all apprehension disappeared. He calmly stretched the boy on a bench and worked on him whilst we organized a stretcher from the Out-Patients. I was deeply impressed.

When he returned from Leeds in 1933, he took me under his wing as his personal technician and contrary to the statement in the extracted letter, 23rd July, 1966, did do some very exhausting research on gastric outflow, modifying Gaddum's Recorder to suit his own requirements. He was interested in any research of a physiological nature, for instance, he, with Lord Brock, took the first pressure recording of man's pulmonary circulation. That was about 1934.

He was a very austere man, sometimes very strict, but he had a wry sense of humour which was only seen by his closest associates, and he was afraid of nothing.

A trip back to Tunbridge Wells from London Bridge via his home at Burgh Heath the day Biggin Hill Aerodrome was bombed was, to say the least, quite eventful. The sun-roof of his old Morris was open, it was a beautiful day. Take cover was the order, but he insisted we get back to Tunbridge Wells. Every time we were stopped by the L.D.V's. or A.R.P. he assured them I was spotting through the open roof. He never said a truer word.

His yearly check through student record cards was full of anecdotes, about some student's father, or names came from the past with memories of an early Residents' Play, a Firm's dinner or a trip down Crosby Row on a bike with a bag at the back. Baker will verify this, he assisted with this check long before me.

Whilst not a Guy's man in the true sense of the term, twenty-three years' service working under the direction of the late Professor Spurrell is something

to be remembered and most of my memories are happy ones. I enjoyed working with him though at times we had our differences of opinion. When I was in trouble he was always considerate and helpful.

I offer my condolences, perhaps a little belated, to Mrs. Spurrell and his family.

DAVID H. GADD.
Laboratory Manager,
Faculty of Rural Science.

The University of New England,
Armidale, N.S.W.,
Australia.

Get "inlay minded"

SIR,—I should like to refer to a recent article by Professor Tulley in the *Gazette*. In this most interesting article on the dental curriculum there occurs the statement "The need for advanced restorative work recedes with improved early dental care."

Assuming the meaning of the phrase " advanced restorative work " to be cast gold and porcelain crown work, then I feel this to be a most erroneous point of view. To judge the importance attached to these techniques, one has only to consider the keen interest being shown by the profession in the Metropolitan Branch of the B.D.A.'s current programme of lectures inaugurated by Mr. Allan Thompson under the heading " London Restorative Year."

Following Mr. Thompson's Presidential Address, a similar point of view to that which I take to be Professor Tulley's was put forward by one speaker only. Both this speaker and Professor Tulley would not, I think, claim much experience of general practice. In general practice I think it would be generally held that it is the "improved early dental care " which makes the availabilty of "advanced restorative work" so very necessary. Without the former the latter is not required.

" We are all periodontists now", but a tooth has not only to be kept healthy in a healthy mouth, but often restored, and in this field a gold casting has no equal. Sir William Kelsey Fry told us to get "inlay minded", an axiom of continuing importance I would have thought to all successful conservative practice.

Yours, etc.,

DAVID PLOWMAN.

7, Harcourt House,
19a, Cavendish Square,
London, W.1.

We'll keep a welcome in the Valleys

SIR,—At a time when ancient Saxons and Normans have been so much in the news, it is a matter of interest (if not of regret) that there are still some ancient Britons in existence, and that they are apparently located at Guy's.

Yours, etc.,

G. L. DAVIES.

Oakfield,
Hay-on-Wye,
Hereford.

SIR,—Dr. Tudgay's advice published in your last edition is not, I am sure, appreciated by most Guy's men, past or present. If his letter is serious it is unreasonable and bigoted; if humorous, it is lacking in taste.

It unfortunatetly supports the suggestion of a number of South Africans in your recent correspondence that we should just put our own house in order.

Yours, etc.,

PETER STILES.

Orthopaedic Department,
Saint Bartholomew's Hospital,
London, E.C.1.

SIR,—No welcome in this valley for Dr. Tudgay. I am unable to comprehend the motives which led Dr. Tudgay to write his anti-Welsh letter, published in the last issue of the *Gazette*. I would remind this gentleman, living in his ivory tower on the Sussex Downs, that Guy's has a strong traditional link with the Principality and that Welsh Nationals have a lot to offer the Hospital whilst they in turn benefit from the best medical education available in Britain. Dr. Tudgay must realise that Welsh students have a different background and upbringing to their more sophisticated English brothers and this inevitably leads to a different approach and reaction to community student life which, in my opinion, is refreshing, stimulating and occasionally boisterous. Denying entry of Welsh students to Guy's would deprive the Hospital of a valuable source of fun, goodwill and, dare I add, excellent doctors of the future.

If Dr. Tudgay would wish to press his arguments further, I would be delighted to meet him at Cardiff Arms Park next April over a few pints of beer and a jolly sing-song, *after* the Welsh victory over England.

Yours, etc.,

D. E. STURDY.

Rothesay,
14, Stow Park Circle,
Newport, Mon.

Poesy Breeds Poesy

SIR,—After reading your last number, the St. Christopher's Poetry Reading Circle had to be specially reconvened to consider a matter of some literary urgency. As a result of our inspired discussion this evening, we are pleased to offer you the first and last of thirty-five stanzas newly composed by our members.

A Beautiful Autumn Discovery

'Twas in nineteen hundred and sixty-six, and of October the fifteenth day,
When E. W. Baxter's poetic gem first saw the light of day:
And all true lovers of poetry cried, "Hooray, hooray,
Another poet is born today"

And especially students of Biology
Lamented that the likes of his poetry
Hadn't been seen before in all their texts;
But, I gainsay, eagerly await his next.

Yours, etc.,

ROBERT OXLADE,
Poet and Tragedian,
Bard of Bermondsey.

St. Christopher's House,
208, Long Lane,
London, S.E.1.

THE INJURIES OF PROFESSIONAL FOOTBALLERS

Their Management and Treatment

by
Dr. A. Woolstone
Hon. Medical Officer, Norwich City Football Club.

Football injuries seem to follow a pattern; some occur when the ground is baked or frozen hard, others when it is soft and muddy. Some injuries are more common at the beginning of the season and then there are those that are more frequent during the pre-season training period before players have had time to loosen up both mind and body. For if a player's reaction time is sluggish, as it can be at the beginning of the season, the delay in co-ordinating mind and body to meet sudden demand could result in a pulled leg muscle.

Initially, good treatment, both physical and psychological, commences on the field. Here it is the trainer's responsibility. He must be a man of great integrity, coupled with a skill and knowledge of the game, without which he will not be able to command the respect and confidence of the players. From his vantage point on the bench his experience helps him to make a spot diagnosis of the injury as it happens and to decide on a course of action from where he sits.

Injured players are instructed not to move until the trainer has been allowed onto the field by the referee; this explains how players are often able to return to full activity so soon after the trainer has administered to them with his magic sponge; thus greatly enhancing the reputation of both trainer and his sponge.

The remarkable effects of the sponge should not always be attributed to witchcraft, for it has genuine physiological properties:— (1) The vasoconstricting and anaesthetic properties of cold water can help to limit swelling and diminish pain. Further, by decreasing the peripheral circulation the refreshing effect of a sponge down with cold water can quickly restore a dazed player to full activity. (2) Although not the most hygienic source, the sponge can supply a much-needed drink to a dehydrated player. Added to this is the sense of well-being the injured player gets when he feels that something is being done for him.

It is true that the modern trainer will often use an aerosol containing a quick evaporating, volatile fluid, which may well produce a more efficient local anaesthetic, but even he will still carry his sponge as a tool of his trade and not just a symbol of his calling.

Once the roar of the fans on the terraces is just a memory and the crowds have started to disperse, the scene changes to the treatment room. These treatment rooms are a feature of all professional football grounds. Some are as well equipped as a hospital casualty department, combined with the facilities of a physiotherapy department.

It is here, often in an atmosphere of great secrecy that the injured players are examined one at a time. Once a firm diagnosis has been made and treatment prescribed, decisions are arrived at concerning their future in light of forthcoming matches. Treatment is started right away. Bruises are dealt with by pressure bandages incorporating pads of sponge rubber which well help to limit the spread of a haematoma. The local injection of an anti-coagulant such as Heparin will help the rate of absorption of a haematoma, and any form of treatment will be employed which will speed recovery to get a player fit for next week's match. There is something to be said for oral preparations such as Chymoral, which have a similar effect, and these, too, will increase the rate of absorption of a haematoma.

Difficulty is sometimes experienced in distinguishing between a muscle rupture and a haematoma. It is important, too, to make a firm diagnosis because as has already been made clear, there is so much that can be done for a bruise and so little for a pulled or ruptured muscle. There is no active treatment for a ruptured muscle, and anything other than rest can easily produce an extension of the damage.

Grazes, although not usually serious, can be extensive, painful and disabling. Although most players are protected against tetanus, there may be one or two who have escaped the net. Players do not as a rule enjoy injections and there are some who dodge them, and this should always be borne in mind. These injuries should be well cleaned and dressed with a tulle gras.

The skiddy, sticky pitch will bring its toll of twist injuries to knee and ankle and these are probably the most common as well as the most disabling of football injuries. In each case a careful, exact diagnosis must be arrived at before the right treatment can be prescribed, so that the player can be brought back into the game without delay. This is the aim of all treatment, to get the player back as soon as possible so that he will be fit to play flat-out for those ninety exhausting minutes. In recent years the local injection of steroids have played a part in the treatment of joint injuries and sometimes seem to assist in speeding up recovery. It must, however, be remembered that this should only be done under strictly asceptic conditions.

Damage to the capsule of the ankle joint at its anterior attachment, causing pain and swelling, is well known as footballer's ankle, and this injury does seem to respond to steroid injection.

The trainer is very often the club physiotherapist and these men have a vast fund of practical experience and a knowledge of football injuries and their treatment, added to which they attend annual courses organized by the Football Association.

There is nothing very particular about the treatment that they

give except that they have more time to give to the individual case. As leg injuries predominate, it is only natural that quadriceps exercises are the most common form of remedial exercises prescribed. As the strength of the muscles increases, so ever-increasing weighted sandbags are suspended on the leg to increase resistance and output.

Many weeks may be required to achieve match fitness, and the process of muscle building is accompanied by light training. Walking is followed by jogging and then on to running and as the player himself is an indicator of the pace of these stages, so he progresses on to sprinting, and then to lapping, using a ball, after which follow twisting and trapping. In spite of pressure from management, public and press, slowly the player passes through the stages of practice games on to reserve games and then, to the accompaniment of press headlines, he finally returns to first team play.

The big moment has at last arrived as he runs out on to the field watched by thousands of critical eyes, and as the fans give him a roar of welcome he will suddenly become aware of the careful attention he has had during the past weeks that has led up to this moment. The player must be confident in himself, for he knows that once the whistle blows he must keep playing for ninety minutes, and ninety minutes can be an awful lot of minutes.

REVIEW

Aitken, Causey, Joseph and Young "A MANUAL OF HUMAN ANATOMY, Vol. 3, THE ABDOMEN", 2nd Edition, 1966. Published by E. and S. Livingstone Ltd. pp. 129. *Price* 16*s*.

The new edition of Volume III of this dissection manual appears to be little different from the first. A few illustrations have been added and some minor alterations to the text have been made, but the most noticeable improvement is that, as a result of these additions, the original diagrams are nearer the relevant parts of the next. The book remains, like its fellows, an excellent dissection guide, and the information is so presented, in a rather repetitive manner, as to give a good basis for a thorough knowledge of regional anatomy, by clarifying key points of functional relationships. However, the text contains insufficient detail for it to be used alone as a text-book for 2nd M.B. The book is designed as an introduction to clinical anatomy and this makes the course clearer and more interesting. The surface anatomy is well taught in a series of practical classes at the end of the book; the lymphatic drainage, which cannot be dissected, is emphatically described, in relation to the whole region and to the more important organs individually. The osteology of this region is not described as clearly as in other volumes, but there is a useful practical class on the subject.

The diagrams are rather small and often difficult to relate to the dissection, but once understood they aid the learning and are simple enough to be reproduced in examinations. This manual will not, and is not intended to, replace an atlas and a detailed anatomy text-book, but what it aims to do is done well. Its course is used by the Anatomy Department and is therefore a wise buy; but students who have a copy of the first edition need not feel that their chances of passing 2nd M.B. would be much improved by buying a copy of the new one.

A.P.H.

NURSING SECTION

The Clinical Teacher

It is now ten years since the first experimental scheme was launched in Scotland, using Clinical Teachers to help with the practical training of the student nurse in the wards. This scheme was such a success that in many hospitals the Clinical Teacher has become an established member of the teaching team.

Here at Guy's this form of teaching was introduced in 1959 with the appointment of an experienced ward sister for one experimental year. From these early beginnings, Clinical Teachers are now working in the medical and surgical wards, the midwifery department, main theatres and the Evelina Children's Hospital.

The purpose of a Clinical Teacher is to develop the practical skills of the student nurse in their natural setting—the wards. It is a recognised fact that the ideal person to instruct the students in the art of nursing is the ward sister herself. Since the days of Florence Nightingale, this has been one of her main functions, but in recent years, however willing she may be, she finds it extremely difficult to teach due to the innumerable and increasing calls upon her time—and of course the decrease in working hours. The Clinical Teacher, on the other hand, has no demands on her time other than those made by the student nurse. She plays no part in the administration of the wards in which she works, so that she can spend all her time with the nurses, be it cleaning bedpans or caring for those who require the most complicated of nursing treatment.

The Clinical Teacher must at all times be aware of the ward situation as a whole. It is in conditions of rush and shortage of staff that the nurse finds her own short cuts which often lead to inefficiency and inadequate nursing care. The Clinical Teacher as a member of the nursing team cannot condone such practices and must teach the nurse methods which will produce the best nursing care in the shortest possible time. Since the introduction of the 42-hour week and all that it entails, pressures have been brought to bear on the student (particularly the most junior), which seem to be almost unsurmountable, and there is little the Clinical Teacher can do in this situation other than work alongside the nurse and give her emotional support.

From October, 1965, the introduction of the 1962 syllabus has brought changes to the work of the Clinical Teacher, particularly those who are in the general wards. They now spend approximately 27 weeks of the year with the Introductory Course nurses, teaching the basic and elementary nursing skills, both in the wards and the classroom. During the period when there is no course, the Clinical Teacher continues to work with the newest entrants to the wards. The function of the Clinical Teacher here at Guy's has to be re-assessed in the near future, bearing in mind the Introductory Course on one hand, and on the other hand the part the teacher has to play in the education of the more senior nurses in the wards.

We would like to take this opportunity of thanking all the ward sisters for the co-operation and welcome extended to us when working in the wards.

SISTER E. M. HODGSON.
SISTER J. BROTTON.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister B. Higginson (née Wreford), Guy's 1958, to the School of Nursing.
Sister V. E. Wild, Guy's 1963, to Job Ward.
C/N I. Cleghorn, not yet placed.
S/N E. Charron, to Nuffield C Floor.
S/N I. Corner, to Casualty.
S/M P. T. Philip, to Victoria Ward.

DEPARTURES

S/N J. Allford, from Barnabas Ward.
S/N A. Hoather, from Miriam Ward.
S/N R. Phillips, from Christopher Ward.
S/N M. Tucker, from Cornelius Ward.
C/N C. Turner, from Cornelius Ward.

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SPORT

RUGBY FOOTBALL

Guy's have continued to play good, exciting football over the last two weeks with the result that they defeated Bedford a fortnight ago by 9 points to 6 in a very exciting match, with Rowlands scoring the winning try in the last minute. This match was a pleasure to watch, particularly the sustained effort of the hospital throughout the whole game. The determination of the side to win in the last minute after being held by a strong Bedford side was most encouraging.

Unfortunately the same standard of Guy's play came only in sporadic patches against Metropolitan Police, resulting in Guy's suffering their heaviest defeat of the season, by 13 points to 3. The Police are a strong side, if somewhat robust, and took their chances well to score ten points in the last quarter of the game. Guy's had their chances to score, one of which should have resulted in a try for John Davies but for a forward pass. This may have been Davies' last game for Guy's in a career of just over five seasons. He has been virtually an ever-present in the Guy's fifteen since coming to the hospital, and has been of great service to the club both on and off the field, culminating in his leadership and example in winning the Cup for Guy's last season.

Even allowing for this rather disappointing result against the Police, Guy's have had their best start to a season for many years. The members of the side give a lot of the credit, and quite rightly, to Dr. Burry, the former All Black back row forward, who has trained and influenced the side into a unit rather than fifteen individuals. Guy's forwards have always been quite strong in the tight and in line-outs, and their big failing in recent years has been poor loose play. "Good ball" from the loose has been stressed as the way to win matches ever since the All-Black tour of a few seasons ago, and this policy has at last been hammered home by Dr. Burry, with the result that Guy's forwards have been giving their backs more chances with obvious results.

We must apologise to all Guy's men who have been inconvenienced by our not publishing a full fixture list at the beginning of the season. Below we publish the remaining fixtures up to the end of this year.

SOCCER

Guy's eleven has not been successful so far this season, to say the least, with one draw and a string of defeats only to their credit. Some of the defeats have been very heavy, and hopes for their chances in the first round of the University of London Cup are not very high. However, they play the Royal Free Hospital, and they must come good soon—let us hope that it is this Saturday.

HOCKEY

After two defeats, Guy's had a fine win against the Honourable Artillery Company, scoring four goals to their opponents' single effort. Guy's have a side capable of some fine results this season, and one hopes they will fulfill their promise. Prior to last week's win, they were defeated by three goals to one by Teddington second eleven, in a not very distinguished match.

GOLF

Guy's reached the final of the Hospitals' Cup by defeating Middlesex Hospital by three matches to two, with a weakened side due to the Final M.B. examination. Guy's are certainly favourites for the final, and all being well should manage to retain the trophy.

DIARY

LADIES' HOCKEY.

November. Wed., 2nd—University College. Home.
Wed., 9th—Royal Veterinary College. Away.

SQUASH.

November. Tues., 1st—Eton Manor. Away.
Tues., 8th—Charing Cross 2nd V. Home.
Thurs., 10th—Bart's. Home.

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RUGBY FOOTBALL. [Remaining Fixtures up to January, 1967]

October.	Sat., 29th—Leicester University. Away.
November.	Wed., 2nd—London University. Away.
	Sat., 5th—Old Blues. Away.
	Sat., 12th—
	Sat., 19th—
	Sat., 26th—Cheltenham.
	Wed., 30th—Buckinghamshire County R.F.C. Home.
December.	Sat., 3rd—Streatham/Croydon. Home.
	Sat., 10th—Old Cranleighans. Home.
	Sat., 17th—Esher. Away.
	Sat., 24th—
	Sat., 31st—Old Merchant Taylors. Away.

SOCCER.

October.	Sat., 29th—Royal Free Hospital. Home (London University Cup).
November.	Wed., 2nd—Varndean G.S. Away.
	Sat., 5th—U.C.H. Home. (London University League).
	Wed., 9th—R.M.A., Sandhurst. Away.

HOCKEY.

October.	Sat., 29th—Kingston G.S. Away.
November.	Wed., 2nd—St. Mary's Hospital. Away.
	Sat., 5th—Wimbledon 2nd XI. Home.

REPORTS & RESULTS

RUGBY

GUY'S v. BEDFORD

At H.O.P. 15th October, 1966

Result: won 9—6

Guy's had their best win of the season so far when they beat a strong Bedford side which included "Budge" Rogers, last season's England captain, and international centre Geoff Frankcom. The game was full of variety, and as exciting as one could hope for.

The sun was shining, and in front of a fair crowd Guy's kicked off. The play was hard from the start. There were several optimistic attempts at scoring from penalties, neither side achieving anything until Bedford were awarded a penalty kick on the Guy's "25" line, from which they scored the first three points.

This setback did not affect Guy's who continued to press. There was a scrum on the Bedford "25" line. Bedford heeled the ball and Swift tackled the scrum-half, the ball went loose, was kicked forward, there was a short struggle and Swift touched down. Elliott failed to convert, thus the score 3—3.

As the game progressed Guy's showed dominance in the lineouts, Kingdon and Cockburn jumping very well. The forwards played hard, with Curzon particularly evident in the loose. The Bedford centres were running well, but Guy's tackling by the outsides effectively blocked any dangerous moves.

Just before half-time Guy's were awarded a penalty, which they quickly took. Bedford had not retired ten yards and so an attempt at goal was made by Osbourne from the new position. A beautiful kick from thirty-five yards put Guy's in the lead 6—3.

During the early part of the second half a loose ball from a Guy's threequarter movement was quickly picked up by Bedford. Attackers greatly outnumbered defenders and it looked as though Bedford could not fail to score, but a forward pass spoiled the chance. Bedford continued to attack, but Guy's countered every time and there were some fine runs by Rowlands, with the threequarters keeping the game open. The Bedford number 8, Wilcock, unfortunately sustained a knee injury and had to retire.

Bedford were moving forward on Guy's "25" line when a well-placed cross kick caught the Guy's defence unawares and the race to touch down was won by Bedford. Their attempt at conversion never rose above ten feet, and so the score with only ten minutes to go was level 6—6.

The atmosphere was tense and Guy's pulled out all the stops. A loose scrum on the Bedford's "25" line found Swift in the middle, so Sharp, acting as scrum-half made an intelligent pass to Ross on the blind side. Rowlands was with him and crossed the line. Osbourne failed to convert, but this was the final score—9—6.

This was a well-deserved win by a team full of spirit. There was a fair crowd, but a game like this deserves support, for it was inspiring to see Guy's play as they did.

Guy's: D. R. Elliott; J. Ross, M. Cheesebrough, D. Osbourne, I. Morgan; B. Rowlands, P. Swift (Capt.); E. Neville, G. Hey, R. Hughes, A. Kingdon, J. Cockburn, H. Sharp, C. Neville, D. Curzon.

Bedford: J. Smith; R. Fletcher, N. Boult, G. Frankcom, J. Philbrook; R. Butt, R. Smith; M. Buck, N. Barker, M. Cosby, M. Marson, J. Bicknell, R. Slaughter, S. Wilcock, D. Rogers (Capt.).

M. J. LIGHT

SOCCER

GUY'S v. ST. MARK'S COLLEGE, TWICKENHAM

At H.O.P. Saturday, 15th October, 1966

Result: lost 3—6

It was hoped that we could have three teams this season as the intake of freshers into the club looked promising, but it now looks as though there will be difficulty in putting out two teams. The second eleven had their first

game cancelled, only seven players being available. If this club is to have a chance in hospital football, there must be a hundred per cent support from all its members. Players must attend regular training sessions, as fitness goes a long way to winning matches.

Looking for their first win of the season, Guy's played some confident football in the opening minutes, but were soon upset by defensive mistakes. St. Mary's opened with two easy goals which could have been avoided by tight marking. The visitors' wingers were given far too much room and took advantage of it. The constructive football of both sides was ruined by missed chances in front of goal. Guy's scored their first goal through a penalty by Lindridge, but soon lost the chance of pulling level when St. Mary's scored again. Again Guy's scored, this time through Ward, but in the second half defensive blunders allowed St. Mary's to score three goals. Ward scored the final goal for Guy's.

D. LINDRIDGE

GUY'S v. CLARE COLLEGE, CAMBRIDGE

At Cambridge Saturday, 22nd October, 1966
Result: lost 4—2

Guy's made the long journey to Cambridge, and, after lunch and a tour of the college, kicked off in good conditions. The Hospital started with good football and were soon rewarded with a goal by Ward. Guy's continued to play with verve, but the opposition scored due to the inevitable defensive "slip". Following this, Clare scored two more goals which seemed to most of the Guy's players, but not the "amateur" referee, to be definitely offside. However, Ward again scored to reduce the margin.

After half-time Ward was forced to retire through injury, and with Carter and Dutta ailing from the first half, the Hospital was hard put to contain the opposition's attack, which only, however, scored one more goal.

This was a game, unfortunately spoilt by poor refereeing and petty fouls, which Guy's should have won.

HOCKEY

GUY'S v. TEDDINGTON 2nd XI

At Teddington Saturday, 15th October, 1966
Result: lost 3—1

This defeat was basically due to a failure to adapt to unusual conditions. Guy's played the wrong sort of game on a very slow and uneven pitch; there was too much dribbling and short passing. More long hitting and enthusiastic chasing was required, and Teddington supplied these attributes in full measure.

White in goal had an unlucky day, while both backs emerged with credit from heavy pressure. Kendrick and Pearson at wing-half tended to commit themselves too early. Both insides carried the ball too far—quicker, thoughtful passing is needed here. Steer was marked by a very efficient half; Cripps on the left-wing made good use of his opportunities. Dodd, in the middle, made things difficult for himself by not moving around enough off the ball

Teddington were on top for the first half, and led 2—0 at half-time. The first goal followed a free-hit taken just outside the circle; the ball was not cleared as quickly as it might have been, and their centre-forward scored from a narrow angle. The second goal was the result of a quick bout of inter-passing among the inside-forwards.

The second half was more even, with Guy's producing a more suitable mixed brand of hockey. After quarter-of-an-hour, Pearson took advantage of a poor clearance, centred from the left-wing, and Appleby pushed home the rebound from the goal-keepers' pads. This was immediately followed, however, by a lucky Teddington goal. For the remainder of the game, Guy's had more of the play, but were unable to create many chances, though they did manage to miss another penalty flick; it is essential that Guy's take advantage of any future flicks—they are few and far between! This was Guy's last real chance, and Teddington ran out worthy winners.

Team: N. White; M. Velecott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; D. Steer, H. McMichen, N. Dodd, M. Appleby, S. Cripps.

M. APPLEBY

GUY'S v. IMPERIAL COLLEGE

At H.O.P. Wednesday, 19th October, 1966
Result: drew 0—0

In spite of a pitch made heavy by recent rain, this was a good, fast game, with Guy's slightly the better of two evenly matched sides. The main reason for Guy's only drawing a game they might well have won was the lack of thrust of the three inside-forwards near goal. The defence again played well—it would be invidious to single out names here—and both wings also had good games.

Both sides took some time to settle down in the conditions. Although Imperial College held territorial advantage for the first-half, they never created any clear-cut chances against a defence that gave nothing away. The Guy's forward line, of which little had been seen up to the interval, came more into the game in the second half. Combining much better, they took the pressure off the defence, and in general most of the play after half-time was centred around the Imperial College goal. That the score-sheet remained blank at the end was due to a combination of bad luck and ineffective finishing by the inside trio.

Team: R. Dunbill; M. Velacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, H. McMichen, D. Steer, M. Appleby, S. Cripps.

M. APPLEBY

GUY'S v. HONOURABLE ARTILLERY COMPANY

Away Saturday, 22nd October, 1966
Result: won 4—1

Against a rather week H.A.C. side, Guy's recorded their first win of the season. The team has been playing good hockey, better than results would indicate, without scoring the goals, and a change of luck in this direction was long overdue. On an untrustworthy pitch, and against two rather slow-turning backs, the through pass was used to good effect; this resulted in more goal-scoring efforts than in previous games, and this inevitably led to more goals.

After scrappy play in the first five minutes, it soon became apparent that the Guy's forwards had the edge over the H.A.C. defence in terms of speed. Encouraged by our early goal from Steer, who scored with a shot via the goal-keeper's pads from the edge of the circle, Guy's proceeded to play good, constructive hockey. For the rest of the half, the H.A.C. goal-keeper was an over-worked man, and he conceded two more goals within a minute just before the interval. First McMichen made an individual run from the half-way line, scoring with a reverse-stick shot —a fine goal Then J. Crafts, picking up a poor clearance on the "25", dribbled into the circle, and coolly picked his spot.

So the second half began with Guy's

deservedly leading 3—0, and one awaited the inevitable relaxation. Sure enough, it came, and H.A.C. scored from a short corner after about ten minutes. Happily, Guy's recovered well after this set-back, and were on top for the rest of the game. McMichen and Dodd went near with good efforts. Cripps, taking a first-time shot at a centre, contrived to shatter one of the many plate-glass windows on the third floor of an office block behind the opposition goal! Eventually, Guy's scored a deserved four goal five minutes from the end when Dodd ran onto a through pass from McMichen and scored with a crisp shot.

For the first time this season, there was real co-ordination between the attack and the defence, with insides and wings going back for the pass from the defence, and the halves supporting the forwards well in attack. This enabled pressure to be kept on the H.A.C. defence by sustained attacks. However, there was still too much aimless and thoughtless pasing—it is no good passing without first looking. One vital lesson emerged from this game—the value of shooting at every possible opportunity. All in all, this was a good team performance all round.

Team: N. White; M. Velacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, H. McMichen, N. Dodd, D. Steer, S. Cripps.

M. APPLEBY

GOLF

Semi-final Hospital Cup
GUY'S v. MIDDLESEX HOSPITAL

Hendon Golf Club 12th October, 1966

Result: won 3—2

D. Adams bt. P. Mcsorley, 1 up.
P. Ellis bt. A. Rickards, 3 and 2.
B. Bevan-Jones bt. J. Spillane, 5 and 4.
A. Philips lost to D. Nairn, 4 and 3.
K. Weir lost to J. A. Chapman, 6 and 4.

The tie was played at Hendon Golf Club on a fine October afternoon—it was a shame that recent heavy rain had made the fairways depressingly muddy and the green impossibly tough. Nonetheless, the first three Guy's players were each round in the middle seventies.

Kirk Weir had many an argument with the local timber and bewailed the absence of a chopper from his more than adequate golfing equipment. On the third hole alone he paid three visits to the trees and ended by holing a tricky 15-footer for his nine; his opponent won this particular hole with a seven, and the match by 6 and 4.

Alan Philips surrendered his unbeaten record to some tidy golf by D. Nairn. In the bar afterwards Philips was unusually quiet. He rushed off early to administer to his ailing girl-friend pausing only to wipe the mud from his eye.

It was a catastrophic start for Bruce Bevan-Jones. But from the 5th hole to the end of the match he was two under fours and this was much too good for a moderate opponent. (On behalf of the golf club I would like to congratulate Bevan-Jones on his recent qualification as a doctor.)

After lunching on a Mess bar, Peter Ellis lost the first hole comfortably. Fortunately, however, his opponent developed an alarming slice and Ellis finally won on the sixteenth green.

David Adams played his usual immaculate golf and holed the course in 74 shots; this constituted the best golf of the day and his opponent must be commended on taking the match to the last green.

Arrangements at Sundridge Park Golf Club

In the coming year Sundridge are going to accept only 20 Guy's golfers. This, however, does not mean that the Hospital Golf Society is restricted to 20 players. We have a very full fixture list with other hospitals and we are nearly always short of players. Anyone who would like to play in these fixtures is asked to get in touch with Noel Curry, the Club Secretary.

PETER ELLIS

CRICKET

CRICKET AVERAGES FOR 1966 SEASON

Batting

(Qualification—5 innings completed)

	I.	N.O.	R.	H.S.	Av.
Butchey	27	5	984	106*	44.7
Swift	14	6	278	51*	34.7
Powell-Jackson	12	1	381	61	34.6
Clark	26	7	539	93*	28.4
Appleby	22	6	448	42*	28.0
Chase	7	0	194	82	28.0
Griffiths	13	2	269	50	24.5
Silk	23	2	443	77	21.1
Gillham	26	0	488	51	18.8
Steer	9	4	89	21*	17.8
Pearson	16	5	166	55*	15.1
Davoodbhoy	8	2	78	21	13.0
Crafts	12	2	107	36*	10.7
Carruthers	5	0	47	22	9.4
Beacham	11	6	29	11	5.8
Thompson	11	0	60	21	5.5

*Not out

Bowling

(Qualification—10 wickets)

	O.	M.	R.	W.	Av.
Davoodbhoy	244.1	49	642	46	14.0
Steer	152	31	465	25	17.8
Pearson	126.3	17	439	23	19.1
Crafts	104	18	342	17	20.1
Appleby	64.2	14	222	11	20.2
Clark	314	87	881	43	20.5
Beacham	281.2	48	781	38	20.6

We must apologise for the delay in publishing the above averages.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Child Psychiatry**, vacant on 1st January, 1967, with appointment to 30th September, 1967, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **12th November, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar/Registrar in Venereology,** vacant on 1st January, 1967, with appointment to 30th September, 1967, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be returned not later than **12th November, 1966**.

PASS LISTS

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Primary F.F.A. Examination

M. C. W. Morgan D. G. Nancekievill

J F. Murray

UNIVERSITY OF LONDON

M.D.S.

J. W. McLean

UNIVERSITY OF OXFORD

2nd B.M. Examination

Special and Clinical Pathology

S. R. C. J. Stanley-Little

PERSONAL

FREEHOLD HOUSE FOR SALE. Built 1963; four beds, open plan, under-floor heating, garage. Forest Hill. Convenient Guy's, King's, Maudsley Hospitals. Price £7,350. Contact Dr. I. G. Christie, York Clinic, Guy's Hospital, or 'phone FOR 3922 on or after 31/10/66.

TYPING, Duplicating, efficiently carried out. Own business just starting. Ring Margaret Dean, Leatherhead 2493.

TO LET, FURNISHED: Brand new luxury flat, three rooms, kitchen and bathroom, own garden, central heating. Swan Street, S.E.1. (Seven minutes' walk from Guy's.) £12 p.w. 'Phone: HOP 4829.

LOCUM. Guy's Dental Surgeon available three to four months from end of January. London and Surrey. Ring 01-399 1490 (evenings).

UNIQUE OPPORTUNITY for Trainee Assistant to work in Kensington Practice—N.H.S. and private. Special training in obstetrics, gynaecology and electrocardiography. British male. Ample time for study purposes. Salary and car allowance as recommended by the Council. Apply Dr. S. Balfour-Lynn for appointment, Tel: KNI 2468.

TO LET—for one year, furnished cottage in centre of village near Lewes. Two bedrooms Box No. 2910/1.

CHANGES OF ADDRESS

Miss A. Abernethy, 1, Styal Road, Wilmslow, Cheshire.

R. Boggia, Esq., B.D.S., L.D.S., 218, Chepstow Road, Newport, Mon.

B. L. Copley, Esq., M.B., B.S., Quarry Bank, Pencerrig Street, Pontypridd, Glam.

Dr. T. T. Davies, Fosmo, Aberdovey, Merionethshire.

Dr. R. I. Henry, c/o Brantford Clinic, Brant Avenue, Brantford, Ontario, Canada.

Dr. F. D. Higgs, Protection Britannique Des Enfants, Messaad, Medea, Algeria.

Dr. J. F. Murray, 23, Sydenham Rise, Forest Hill, London, S.E.23.

Miss S. F. Parker, Cherry Tree, Bradford Road, Sherborne, Dorset.

H. E. G. Rees, Esq., Royal Sussex County Hospital, Brighton 7, Sussex.

Mrs. P. R. Richardson, 16, Corrigan Street, *Kingston, Ontario, Canada.*

Dr. J. J. Rippey, 3, Heath Royal, Putney Hill, London, S.W.15.

BIRTHS

MAISEY.—On 9th September, to Irene (née Askay) M.B.B.S., and Michael Maisey, M.R.C.P., of 128, Courtlands Avenue, Lee Green, S.E.12, a son, David William.

JOHNSTON.—On August 20th, to Jill (née Campbell) S.R.N., O.N.C., and Gordon Johnston, a daughter, Andrea, a sister for James.

GHATTAS.—On 1st October, 1966, at St. Joseph's Hospital, Jerusalem, Jordan, to Barbara (née Ellis) S.R.N., S.C.M., O.N.D., and Issa Ghattas, a second son, Salim.

FORBATH.—On August 23rd, in Toronto, to Drs. Anne (neée Kenshole) M.B., B.S., D.R.C.O.G., and Nicholas Forbath, M.A., M.D., F.R.C.P., a daughter, Elizabeth Andrea Harding.

ENGAGEMENT

BLOCH—WOOLSTONE.—The engagement is announced between Thomas, younger son of Mr. and Mrs. H. Bloch, of Bulawayo, Rhodesia, and Susan, eldest daughter of Dr. and Mrs. A. Woolstone, of 3, Fairmile Close, Lime Tree Road, Norwich.

MARRIAGE

NORTON—BRETT.—On June 16th, 1966, at Woolwich, S.E.18, John Arthur Norton to Dr. June Elizabeth Brett.

DEATH

MORICE.—Charles George Frederick Morice, F.R.C.S. (Edin. 1898), M.R.C.S., L.R.C.P. (Lond. 1892), on 15th September, 1966, at 24a, Hill Street, Wellington, New Zealand, aged 98 years.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

EDITORS M. F. D'SOUZA and D. S. ROBINS

SPORTS CORRESPONDENT G. E. RATCLIFFE

NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2042

GUY'S HOSPITAL GAZETTE

EDITORS M. F. D'SOUZA and D. S. ROBINS
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FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2043

PASSIM

What's the Alma Matter?

The world of British Medicine, for some time now has been beset with constant moanings and groanings about nearly everything. Both in and out of the Health Service, nobody and nothing seems to be living up to what everyone (else) is expecting.

The *Gazette* has, unfortunately, not been able to remain aloof from this general free-for-all and many Passims are typical examples of this general spasm of criticism and denigration. This week, however, we hope partially to reverse the trend and hand out some honest to goodness praise—at least within the hospital.

Top of our list comes the too-often forgotten Food department, which must get the *Gazette's* "Eulogy of the year". Nowhere could we find criticism of this department, it provides a trouble-free, no nonsense service that is an inspiration to everyone.

Taking the other departments in approximate alphabetical order and singling them out for their prowess, co-operation in patient-care or general efficiency and "magnanimity". We have initially the Blood Transfusion service which, despite heavy odds, manages extremely well. Also the Forensic Medicine department deserves praise, as does the Medical School Office. The Guy's School of Nursing is one of the best in the world and, of course, it need hardly be added that Paediatric and Thoracic Units are internationally famous and an abiding credit to the hospital. The Department of Social Work and the York Clinic must get worthy mentions, and we also have high hopes for both the new Renal Unit and the General Practice Research Unit. One could go on.

But.

Go West, Young Man

" If Winter comes, can Spring be far behind?"
Shelley.

An ice curtain has fallen across the face of Britain, we may paraphrase, and the next few months will display their traditional annual souvenirs in ordered sequence. We will be reminded of even more economical methods of central heating, carols, of department store sales and still more exclusive or cheap ski-ing holidays. And to top it all we are destined to be economically defrosted, an event which, when coupled with the possibility that the junior hospital doctors may actually get some of their pay award off the ledger books and into their pockets, will further serve the administrative complacency. Astrologists or no, the patterns will be once again imprinted on our lives, and we will manage somehow, of course.

Man distinguishes himself through his ability to see into the future, especially during times of adversity. Consequently, the many plans that spring and summer demand will be laid down in these next few months. Amongst that unique sub-species, the medical or dental student, there will be a number who will establish which country it will be that brings yet further broadening of their education. We have here and now a new age of travel which vies with that of the Victorian gentleman, but which is more widely experienced. There is, nevertheless, a restriction of a different type—lack of information.

The information that there is on the many places, how to apply, how to finance, what opportunities for work, all resides in the voices of friends and acquaintances, a surfeit of pamphlets that are unread because they are in surfeit, and the widely unread notice-board posters.* While the back of the "adventurous" travelling student is patted in admiration once he has returned and all are told what a fine specimen he is, etc., there is still little done in the way of active encouragement, especially to those who have not yet gone. This prevailing two-faced attitude merely adds to an environment wherein the student qualifies and matures in spite of rather than because of.

The time is now ripe—it has been for some time and the customers will very soon be seeking better sources of fruit—for medical education authorities to decide one way or the other their honest attitude and then to take *active* steps to promote that attitude. To hide behind the transparent cover of "we must not spoon-feed them" is pardonable only if someone else is being more efficient in the promotion of educational travel, which no one is. Lack of exposure is a barrier which a few will surmount on their own, but which is very real for the majority. That there is a barrier is undoubted: Gray's Elegy was a reputed eight years in the distilling.

*The International Federation of Medical Student Associations arranges foreign clerkships, preclinical and clinical, in nearly 30 countries spread over the world. The British Medical Students Trust annually makes cash grants, at present still rather small, to students traving abroad to further their medical education. Information regarding both these items may be obtained from B.M.S.A., B.M.A. House, Tavistock Square, London, W.C.1.

Inflam

The fly has always been regarded as a sucker for entering the parlour of the spider. Yet he was like most of us—in search of happiness—and was in fact basically happy, even if at that moment happy-go-lucky. But with that curious human masochistic drive, his story has always been told to point a moral that sneers, in the nicest possible way, at his innocent behaviour, while leaving the villain of the piece, the spider, untouched in its amorality. More to the point would be the moral of condemning the spider and trying to improve the parlour.

For two nights now, since September, the Students' Club Bar has been the site of an "Inflammation"—a *Gazette*-instigated move to improve use of the East Wing, Passim being only too conscious of the trap of unconstructive criticism. The Students' Club committee have responded admirably in executing the idea with enough efficiency for the word "Inflam" to have already about it the aura of a long-established and well-entrenched Guy's happening. In support of Passim's plea for wearing down the ill-founded, ill-supported and ill-productive social xenophobia, the parties have been opened to all and attended by people of many parts of the Guy's working and studying scene. To an effect, indeed, that were we an insipid socialite column we would be moved to sentences like "there seem to be more happy, smiling faces in evidence as one moves about the environs during the succeeding days."

The first of the quarterly Celsus Balls will soon arrive. With this combination there is even hope that the relative emptiness of the East Wing will succumb rapidly in the manner of a social Arthus Phenomenon.

MR. J. C. CARLISLE

It is with deep regret that the Guild of Ex-Patients and Friends of Guy's Hospital announce the death, on 23rd September, 1966, of Mr. J. C. Carlisle, who was a member of the Guild since 1938, and Hon. Treasurer from 1956 to April, 1966.

GUY'S DIARY

NOVEMBER			
15th	Tu.	1.00	Clinical lecture. Dr. MACKENZIE. "Epilepsy".
17th	Th.	1.00	Clinical lecture. Dr. HARDWICK. "The Medical Aspects of Fitness to Drive a Car".
17th	Th.	5.00	Neurosurgical Round: In the Clinical Theatre. Conducted by Mr. MURRAY FALCONER.
18th	F.	1.00	Clinical lecture. Prof. TROUNCE. "Some Problems in the use of Antibiotics".
18th	F.	2.15	Combined Round. Dr. DEUCHAR.
21st	M.		ART SOCIETY EXHIBITION. In the Gordon Museum till Fri., Dec. 2nd.
24th	Th.	1.00	Clinical lecture. Mr. GLOVER.
25th	F.	1.00	Clinical lecture. Dr. SCOTT. "Diarrhoea".
25th	F.	2.15	Combined Round. Dr. BATTEN (St. George's Hospital).
26th	S.	1.00	Clinico-Pathological Meeting: In the Clinical Theatre. Exhibition: Urethral Catheters (in Gordon Museum).

A STUDENT'S VIEW OF THE DENTAL CURRICULUM

By
J. M. A. Wilton

This article is one of the current series in Dental Education and is a purely personal view of the method of dental teaching at Guy's Hospital. It is written not strictly as a student but by one recently qualified.

Since Dentistry has the status of a Degree subject it has been assumed that there is sufficient intellectual content in the course to satisfy this. Dentistry is also, however, probably unique in the constant application of strictly practical procedures and their acquisition can scarcely be described as intellectual although needing a certain theoretical knowledge for their proper use. The subject is thus a rather uneasy amalgam of the purely practical and the purely theoretical. Each extreme has its proponents to the exclusion of their opposites but most would agree that a proper balance is necessary and only differ in where the actual proportions of content should lie. It is only with these premises in mind that any critical evaluation of a curriculum can be attempted. The division is made even more real by the difference between undergraduate life and life in general dental practice. The undergraduate in present conditions acquires facility in a wide range of procedures using an equally large range of materials only to find that when in practice a large number of both procedures and materials are denied him. This places his teachers in a somewhat anomalous position. Are they to teach various procedures in somewhat of a vacuum, knowing that the opportunity to continue their use will be severely limited in the ordinary National Health practice and consoling themselves with the thought that any exercise to practise facility is better than none? Or should they insist on the repetition of the standard types of work found in general practice at a speed consistent with earning a living in that same practice. To take an example, any form of advanced Periodontal Therapy beyond scaling is viewed poorly and paid worse by the N.H.S., but in the Department of Preventive Dentistry all aspects are taught, including surgery and splinting of various types.

All these points must be remembered since the initial formation and, one hopes, constant revision of a curriculum must weigh both academic and general practice points of view and attempt to equate them fairly. No curriculum should be the mere filling up of four years of the student's time on a sort of parole basis with its only goal the ultimate release. To state my own view of the philosophy of a University education in a few lines and to account for the peculiarity

of Dentistry that I have already mentioned, my framework for a curriculum would recognise the following points. A course in Dentistry should provide a necessary theoretical basis for the practical procedures that form a large part of dental practice and this would include the critical appraisal of advances in both fields. Since these critical faculties can only be developed in discussion with teachers and amongst the students themselves, much of the teaching should be on a small group basis. The artificial, although administratively useful, division between pre-clinical and clinical subjects should be done away with and the basic sciences constantly recalled at all stages of undergraduate education. My own personal view is that given these bases, a good general practitioner will be produced and also the necessary academic stimulus given to those with a bias for it. If the difference between teaching in Schools and usage in practice is to be diminished, the lead must come from the fully competent product of the Schools.

The course runs in chronological order and I shall examine the curriculum exactly on this basis and insert some more general comments in conclusion. There is at present a new curriculum awaiting implementation but many of its aspects require the new Tower Block and as this scheme seems in perpetual abeyance, it cannot yet be criticised either from its working or its theory.

Most students enter the course exempted from the first year, having gained "A" level exemptions and start a course of Anatomy both General and Dental (Special), Physiology and Biochemistry. The courses are extremely condensed since they must be completed in something less than 30 weeks and presumably rely on vacation work to attempt a consolidation and evaluation of the mass of material presented. In spite of often adverse student/staff ratios there is a high degree of group tuition in all subjects, especially in the practical aspects of the work. The aim is presumably to offer a comprehensive account of the normal body and its function and to concentrate on the oral and para-oral structures in particular. It is the only year to approach the structure of the normal University year and the factual indigestion inherent in the short teaching time should be to some extent corrected by independent work by the student in his vacations. The course cannot conceivably be lengthened in view of the general shortage of dentists and any changes would be in relation only to content, e.g., less gross anatomy of head and neck and more oral physiology and cellular biology. At the end of this year the second B.D.S. exam is taken and those successful proceed to the Dental School and a year of Dental Prosthetics.

This commences with a technique course in all laboratory aspects of full denture prosthesis and is combined with lectures in Dental Materials. After about eight weeks the first patient is seen, and, with one member of staff, all clinical procedures dealt with in relation to full dentures. Lectures in Prosthetic Dentistry, laboratory and clinical work in partial dentures and the fulfilment of the work quota occupy the remainder of the year until the examination in July. Recently, lectures in pathology and bacteriology have been introduced, starting after Christmas of each year.

The average student fulfils the quota of dentures within the limit and consequently spends a large part of his time in the laboratory, seeing an average of about twelve patients. Clinics are infrequent but weekly tutorials where one student reads a paper on a specific subject which is then discussed are a redeeming feature. The chief criticism of this period is its completely mechanical nature both in the repetitive laboratory work and the absence of correlation with the previous years biological sciences. The pernicious phenomenon of the quota system has been introduced and an immediate narrow speciality assumed. Two points merit some criticism in the second year. The proportion of laboratory work to clinical experience is weighted too much in favour of the former. A working knowledge of denture construction is surely enough for a dental surgeon. This means more technicians must be employed, and intelligently used to improve co-operation between surgeon and technician. A course in clinical dentistry must start somewhere but ten months in one narrow branch is surely too long. One does not usually teach from the particular to the general and a better use could be made of this first clinical year. Briefly, this would mean dividing the year into roughly three concurrent parts: (1) the consideration of human disease in general and hence the teaching of Medicine, Surgery, Pathology and Pharmacology—made surely easier by the recall of the Anatomy and Physiology; (2) an introduction to Conservative Dentistry via Phantom Head and tooth carving; (3) the introduction of Materials and Prosthetics. The exact proportion of each could be worked out but the basis should be a general year at the end of which the examination in medicine, etc., would be taken, leaving the examination in prosthetics until the time now given to medicine, etc. This is not to denigrate Prosthetics but place it in the stream of dentistry and not in a rather artificial compartment.

After prosthetics comes the Phantom Head course and the introduction to Conservative Dentistry. The acquisition of a minimum technical competence is gained on inanimate sound teeth under somewhat artificial conditions but it is difficult to see how the difficult transition from wooden skull to patient could otherwise be made. Teaching is done in small groups and with a supervision not to be found again during the remainder of the course. The course could be improved, however, in a number of ways. Even with small groups, it is difficult to see all that is going on in a very confined space. Perhaps the use of television would be beneficial here? The adjunctive use of a teaching technician for instruction in the proper use of materials would serve to refresh the memory and the provision of surgical anatomy tutorials would reinforce the practice of extractions, and later, oral surgery. After intermediate and final tests the student then proceeds to the Conservation room for a minimum of six and a maximum of nine continuous months to practise all types of conservative dentistry except crown and bridgework.

Immediately the relatively close supervision of the Phantom Head course is replaced by a complete absence of any formal chairside teaching although a once weekly meeting of the original group takes place for a demonstration. Amalgam cavities are checked by House surgeons of recent qualification and the race is one to acquire the quota

necessary for schedules to take the final examination. In theory the student is probationary for three months and can be returned to Phantom Head at the end of this period for further training, but in practice this is rarely invoked. Surely a case can be made for a practice system with the original (probably full-time) Phantom Head demonstrator and a half-time Registrar being closely responsible for the students' work of all types for this initial period? In this way any difficulties could be dealt with both individually and in group discussion and wider topics discussed such as operating postures, instrument and equipment design and treatment planning. This would release House Surgeons for *their* training and further education and ensure that the student received credit for all aspects of his work, not merely the finished polished fillings. It could also provide the basis for scrapping of the points system and replacement by a merit scheme within the capacity of the individual and rewarding quality not merely quantity. At the end of this six months, an unsatisfactory student would have to repeat a certain part if his work was either poor or deficient in reasonable quantity.

Depending on some mysterious streaming system the student now proceeds to his first Appointment or stays in Conservation for a further three months before proceeding. I shall now discuss each Appointment in turn.

The Children's Department is on the whole good, with a high staff-student ratio, a workable practice system save for the somewhat chaotic first two or three weeks and good small group and clinic teaching. The lack of a points system is appreciated and most students still manage to attain a reasonable standard and quantity of work, progress being assessed during the appointment and at its termination. The only disadvantage is inherent in the three monthly block system itself and this is that orthodontic treatment is rarely complete within three months and a student never sees his final result. The proposed new curriculum may obviate this to some extent.

The Department of Preventive Dentistry (including the Casualty Department) is again well run with adequate clinical teaching, small group lectures and a weekly seminar analogous to that of the Prosthetics Department. The Casualty appointment is both popular and valuable but most students dislike the rather monotonous round of check scales which, unfortunately, comprise the bulk of the clinical periodontal work at present. This has been relieved to some extent by the Hygienists, but since they must also be trained, some of the work will still fall on the students. Proposals are in hand for an increased intake of pupil Hygienists in the new building, but the present small size of the department makes it impossible at present. The appointment is long enough to allow the student an adequate assessment of cases that he starts but the fact that most people take a three-week holiday from an essentially two months' appointment is perhaps a case for taking the Casualty Department out of the Preventive Dentistry sphere and substituting it later in the course on a half-time basis without reducing its length. Apart from being a basic part of dentistry itself, Preventive Dentistry is a useful introduction to Dental Medicine, and if the number of check scales could be reduced,

the department would make a more effective contribution to undergraduate education with a more realistic amount of time spent in the Department and the carrying out of more advanced procedures.

Senior Dressers in the Prosthetics Department attend on a half-time basis and treat more difficult cases than Junior Dressers. They have one tutorial each week and do no laboratory work at all. At the same time they hold the appointment of Dresser to the Director, Conservation Department, and have one clinical demonstration and discussion period a week. The remainder of the time is spent on the Conservation room contributing to the quota necessary for the Finals schedule.

The preclinical part of the Advanced Operative Technique course is done whilst a Junior Dresser in the Children's Department and there follows a three month appointment with one clinical teaching session a week. During the appointment the student is on the Conservation room performing both routine and advanced work. The only requirement is one porcelain jacket crown and one post crown, but many students also construct one bridge, these curiously not being one of the required teaching pieces in the Preclinical schedule. The teaching of A.O.T. is done both by a clinician and a technician, and is confined to the construction of the restorations, the theories, and indications for them being taught in lectures elsewhere.

The final six or three months, depending on the original streaming, are spent on the Conservation room completing the schedule requirements, and for some students a three months' appointment as Assistant House Surgeon attached to a Consultant, assisting in the running of his clinic and carrying out any delegated work on patients from the clinic with the minimum of supervision. These appointments are regarded as merit awards and most of those appointed feel that they gain from them. The Consultant Clinics are attended by all students both as Junior and Senior Dressers, whilst in the Conservation Department and consist of weekly attendances at two Junior Consultant and two Senior Consultant clinics, including the presentation of patients and the opportunity to attend theatre sessions. A wide range of clinical material is seen and most students regard the time spent as both valuable and of reasonable duration. The only criticism is that from the patients' point of view, a whole morning or afternoon is often lost due to the lack of an adequate—or adhered to—appointment system.

During these 2¼ years, the student also attends formal lectures in all subjects ranging from Oral Surgery to Radiology and also attends Local, General and Minor Oral Surgery sessions. During the teaching of medicine and surgery there are lectures and out-patient attendances, ward rounds and revision classes, the latter being especially appreciated. The questions of lecture timing is a vexed one, many being held in the lunch hour or late in the afternoon, and it is interesting to note that the recent Questionnaire sent to students opted for early mornings as the best time for lectures but this would be difficult to arrange for every subject. The other criticism of medicine and surgery teaching is that very little opportunity for discussion and clarification exists but again this would be difficult to arrange in an

already tight teaching schedule. Perhaps attendance at Medical Out-patients as well as Surgical Out-patients would restore the balance here. The rather poor results at the medicine and surgery examinations recently would perhaps indicate that some revision of teaching and student participation is indicated. Or perhaps, since the average student is somewhat short-sighted in regard to examination subjects, doing little or no reading beyond the standard minimum textbooks, any further teaching would only be wasted. I feel that the answer again lies in smaller groups with opportunity for discussion and correction of misconceptions but that students must prepare themselves for these or the whole point would be lost. Most students seem unaware of the fact that to be taught anything is not merely to be a factual receptacle (and preferably a mute one) but that education in the best sense of the word can only come from informed participation. At the moment, due in part to staffing difficulties, there is too little teaching of this type.

In conclusion, several general points must be made which are relevant to a curriculum but not strictly part of them. The block system of appointments as presently used leads to a certain fragmentation of the subject and this is bad for both patient and student. The patient is shuffled from Department to Department receiving spasmodic treatment in strictly specialist procedures and is too rarely seen as a whole. If the system were less rigid, say on a half-time basis rather than massive chunks, both patient and student might benefit. Specialist teaching should be done by the departments concerned but a form of block teaching allowing a patient to receive all his treatment by one student is surely possible. If this were reinforced by a Department of Treatment Planning and Diagnosis and an adequate recall system for patients then much of the material wasted at present could be retained. The present long waiting list in Prosthetics and Crown and Bridge are ridiculous, especially when, due to a lack of recall, the amount of routine conservation work that is usually needed on patients from these waiting lists delays the other treatment considerably.

Staffing is dependent on money available and this is a universal problem but could not more use be made of part-time teachers instead of using them as rather advanced House Surgeons as at present? House Surgeons are also extending their training but due to an overlarge and unjustified part in student supervision, have very little time for their own further education. Some supervision of senior students should perhaps exist but at present far too large a burden of direct supervision and, by implication, teaching, falls on people not qualified to perform the task properly. At the risk of overstatement, the quota system is iniquitous and should be replaced by one of review and credit for actual quality at all stages, not merely numbers of tasks performed. In this way, perhaps, a fairer system of Final examination, especially on the practical side, could be devised with finished patients presented and less stress laid on an artificial practical test. This is to some extent dependent on the University but the regulations are flexible enough and other schools have a comparable system. More

teaching should be done in small groups, especially at the chairside, rather on the model of the present clinics with possibly an essay system in an attempt to extend the students' range beyond the standard tomes and perhaps into original research reports and current periodicals. This would be assisted by the provision of a central Dental Library, the lack of which is a permanent disgrace.

The purpose of this article has been to stimulate discussion by a statement of what I feel personally to be lacking in the present curriculum. I may have overstated my case or omitted points which others may feel equally important and in a discussion of this length, the treatment must necessarily be sketchy. The pursuit of knowledge is dynamic and a system for the acquisition of that knowledge should also be dynamic.

NOTICES

Guy's Hospital Ladies' Association

Mrs. P. Clarkson very kindly invites you to a Christmas "Bring and Buy Sale" at her house, 107, Harley Street, London, W.1., on Thursday, 24th November, from noon until 2 p.m., in aid of the funds for the Guy's Hospital Ladies' Association. Cheese and Wine is included in this very generous invitation.

In order to assist with the catering, Mrs. Clarkson would like to know by the 20th November if you can come.

Do bring things that *you* would like to buy for Christmas, such as Games, Home-made Cakes, Produce of all kinds, Cosmetics, Wines, Linen, etc., but no White Elephants! Please price your gifts beforehand.

If you *cannot* come, any suitable gift would be most welcome.

JANET MCBEATH,
Chairman.

Christmas Concert

The Concert will take place on Wednesday, December 7th, at 8 p.m., in Southwark Cathedral. Programme:

Vivaldi—Concerto for 2 trumpets.

Britten—Ceremony of Carols.

Handel—Coronation Anthem: "Let thy hand be strengthened."

Handel—Organ Concerto, Op. 4, No. 4 in F.

Handel—Coronation Anthem: "Zadok the priest."

Admission by programme on sale at the door.

A silver collection will be taken in aid of the work being done by Dr. Philip Evans, senior paediatrician at Guy's Hospital, and his team, at the Rhi Dong Children's Hospital in Saigon.

Barclays in Southwark

We first opened a branch in Southwark in 1905, and after half a century of developing business, we opened, in 1957, new and larger premises, a few doors from the old building, at

29 Borough High Street

The Manager there is Mr. P. M. Cox, and he will be happy to welcome customers and visitors and to place at their disposal our complete range of banking services.

BARCLAYS BANK

Money is our business

How you can see the world and gain valuable medical experience

(before you settle into general practice)

Would you like to see the Far East, the Mediterranean, or the West Indies? Study the new sciences of aviation, underwater or nuclear medicine? Have complete clinical freedom, modern medical equipment and the opportunity to practise a very wide and varied field of medicine? Lead an active, exciting outdoor life against a world-wide backcloth?

These are some of the opportunities open to you as a Medical Officer in today's modern and expanding Royal Navy. During a 5-year Short Service Commission you can gain valuable, practical medical experience, treating both Royal Navy personnel and civilian families.

And you'll see something of the world—before you settle into the routine of general practice. You will be well paid, with a starting salary higher than that of a civilian hospital registrar. You can study (with financial backing) for higher degrees. You could aim for consultant status. Marriage and other allowances can add considerably to your income. And, if you wish, you can apply for a Permanent Commission after 1 year's service.

3 Ways of Entry

1. As a fully registered doctor; civilian experience counts towards your seniority.

2. During your pre-registration year.

3. As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

If you would like more information, write to the address below, giving details of your age and qualifications. A personal interview can be arranged if desired.

The Medical Director-General of the Navy, Dept. 26FR4, Empress State Building, London, S.W.6

Royal Navy

Music Circle

Tuesday, November 15th—Stephen Coles on the development of organs and organ music.

Tuesday, November 29th—Stephen Walsh, music critic (lately of the *Daily Telegraph*, now on the *Observer*) will talk on a subject to be announced.

Boat Race Dinner

The Annual Dinner of the Guy's Hospital Boat Club will take place on Wednesday, 7th December, 1966, at the "Anchor", Bankside, S.E.1. Time, 8.30 for 9.30. Dress—dinner jackets.

Guy's Hospital Society, Bournemouth and Wessex

The Annual Dinner will be held on Friday, 2nd December, at 8.15 p.m., at the Norfolk Hotel, Bournemouth.

Mr. A. A. Bailey will be in the Chair, and Mr. Jason Brice will be Guest of Honour. All Guy's medical and dental graduates in the Wessex area are cordially invited to attend, and to apply to me if not already in receipt of particulars.

N. J. Wood, *Hon. Secretary.*

51, Lansdowne House,
Bournemouth.

CORRESPONDENCE

Poesy breeds Poesy breeds Poesy

SIR,—If only to pay my respects to the Bard of Bermondsey, I dare to send you some further lines which were composed in response to fevered comments heard at an Examiners' Meeting last summer:

Advice for Tired Examiners

(*and to Examinees for all that*).

In the silent hours before the dawn,
When eyes ache and cheeks yawn,
Numb with cold, blood scarce aflow,
And one's senses senseless grow,
Then is the time to lay aside
Censorious pen and swallow pride.
For naught is gained when nought is given
For answer read and read and riven
To discover any point of sanity
In essay full of gross inanity.

Go off to bed
And rest your head.

* * *

Senate House with its bricks and mortar,
Works us too hard, and didn't oughter!

Yours, etc.,

E. W. Baxter.

Department of Biology,
Guy's Hospital Medical School,
London Bridge, S.E.1.

NURSING SECTION

Priest and Patient

This short article is primarily concerned with Roman Catholics, but I think a lot of my remarks are applicable to members of other denominations.

There is a widespread feeling of reluctance amongst nurses and doctors to call a priest to a patient who is seriously ill. This feeling is expressed in such remarks as " I did not call you sooner, Father, because I was afraid the patient might be upset" or " Please try and make your visit appear just a matter of routine" or " You won't say, will you, that I called you." Very occasionally, there is a head-on collision. " I would be very glad, Father, if you did not see the patient now. I think your visit would upset him." The general assumption behind such remarks is that the coming of the priest is going to frighten the patient into thinking that he is dying. He appears as a harbinger of death. The names that have been used to describe the sacraments administered to the sick—" extreme unction " and " the last rites " have unfortunately fostered this assumption. "Extreme unction" is now called " anointing of the sick", and the term "last rites" is avoided precisely because it is liable to mislead.

The purpose of this brief article is to explain a little of what a priest does, and what a Catholic patient expects from a priest so that doctors and nurses will not be reluctant to call him. It would seem to me that the more you appreciate the help that a patient can receive from a priest, the more likely you will be to regard him as an ally in your work and not as a threat to your patients' contentment and peace of mind. It is because I am so conscious of the real help and comfort that a sick person receives from the ministrations of a priest, that I want you to understand how he assists your work of healing. I do not wish to imply that this is the sole or even primary purpose of the priest's work with the sick, but that his ministrations help and do not hinder.

The vast majority of Roman Catholics expect to be visited by a priest in hospital and welcome his coming. (I think it is true that the majority of sick people, whether Roman Catholics or not, are pleased to be visited by a chaplain, provided he is cheerful, sympathetic and "normal.") When people are sick, they need help to bear their sufferings. Because life in the world is so remote while in hospital, very often sick people think about God and say prayers. They are conscious of their helplessness and need your expert care and attention, and also very often feel a need for "religion". A priest visits to help fill this need for God. It may be to encourage; it may be to put someone's troubled conscience at rest. It was only the other afternoon that a youngish man to whom I had given the sacraments, said " perhaps this is why I am sick—to get me to go to confession after all these years."

The priest does not come simply to offer his human gifts of sympathy and kindness and good humour; he brings a specific, professional competence—to minister the sacraments, from which the sick can derive great strength and courage as well as comfort and a measure of peace. Of course I am not pretending that all Roman Catholics want or accept the sacraments, but it is very rare for a Roman Catholic to resent the priest's visit, and however lax a Roman Catholic may be in the practice of his religion, he still knows that the priest comes for his benefit, even though he may refuse the most important things a priest has to offer.

Many people are under the impression that the sacrament of anointing the sick, or extreme unction is the last sacrament given to a person before he dies. Doctors and nurses are therefore reluctant to call the priest to a person who is seriously sick, because they would appear to be letting the patient know in a roundabout way that he is dying. When the priest anoints a patient he is signing his death warrant. Now this is a completely false understanding of this sacrament. There are many people walking about today who have been anointed at some time in their lives. The prayers used during its administration are all concerned with helping this person get better. The primary purpose of this sacrament is to comfort and encourage. I have been told many times by patients after I have anointed them, that they feel much happier; they feel relieved, or they feel more peaceful: " Thank you so much for all that you have done for me, Father." This is the overwhelmingly common reaction of sick people after they have been anointed. If they were scared before, this has helped to calm them down.

Sometimes I am asked what do I say to patients who are seriously ill and to whom I wish to give the sacraments. In a short article, it is not possible to go into detail, but generally speaking, I simply ask them " would they like the sacraments?" If there is some hesitation, we may discuss the matter. With regard to the sacrament of anointing, I will say "you know there is a sacrament to help you when you are not very well. Would you like me to give it to you?"

The sacrament of anointing is intended to help people cope with serious illness, when there is a risk that they may not recover. To deprive a person of this sacrament through fear of upsetting him is to deprive him of a great source of comfort and peace. It is this failure to realise that the priest appears to the patient as a boon, and not as a threat, that is the cause of the reluctance to " get the priest." Your fears of upsetting the patient are in my experience exaggerated. I think also the emphasis that is placed on trying to make the priest's visit appear routine betrays a lack of grasp of the patient's point of view. I remember a nurse calling me at 9 p.m. one night and being most anxious for me to try and make my visit "routine." The reaction of patients to my coming "out of turn" is not one of fear—"What has happened now?", but one varying from the ordinary query, "What day of the week is it?" to "How nice of you to come again so soon, or at this time of the day". Even in the middle of the night patients have said, " I am so sorry to get you out." I can remember a patient whom I used to visit in Cornelius Ward nearly every day for ten days, saying to me after he had recovered, " It was your saying a prayer with me that kept me trying."

So once again, I can only reiterate that the priest comes to fill a need and the patients look on him as a comfort and help. If this article has helped you to see him in the same light, then the labour of writing it will be more than recompensed.

A. C. FRASER, R.C. Chaplain, Guy's Hospital.

Guy's Hospital Nurses' League

1. *Cosmos and Mabel Bonsor Scholarship.*

Members of the Guy's Hospital Nurses' League are advised that a sum of £150 will be made available within the context of this Scholarship in 1967.

Any League Member, who is formulating plans for Post-Registered Education either at home or overseas, or is intending to visit hospitals and health centres abroad, is invited to apply for this Award. Applications should be made in writing before 31st January, 1967, to: The Matron, Guy's Hospital, London, S.E.1.

2. *Register of Visitors.*

We would welcome the names of more people who would be prepared to visit elderly Guy's nurses in different parts of the United Kingdom. Expenses will be reimbursed when requested. Details should be sent direct to: Mrs. A. Franks, 9, Fairacres, Roehampton Lane, London, S.W.15.

3. In view of revised plans for nurse education and the discontinuation of a compulsory fourth year of training, the League Council has agreed that nurses who trained at Guy's, but left the hospital without completing their contract, may now apply for League membership. Details and application forms from: Matron, Guy's Hospital. (Please mark your envelope "A".)

A. M. JOHNSON,
Matron and Honorary Secretary, Guy's Hospital Nurses' League.

STAFF CHANGES AND APPOINTMENTS

NEW APPOINTMENTS

Sister B. Nichol, R.S.C.N., N.N.E.B. (Queen Mary's Hospital, Carshalton), to the Evelina Hospital.
Sister R. Parker, S.R.N. (University College Hospital), to the Renal Dialysis Unit.
Sister V. Wild, S.R.N., B.T.A. (Guy's 1958-63), to Job Ward.
S/N K. Green, to Cornelius Ward.
S/N E. Hobbs (née Fury), to Nurses Health Service Clinic.
S/N C. Pert, to York Clinic.
S/N E. Read, to Casualty.
S/N J. Tomlinson, to Astley Cooper Ward.

DEPARTURES

Sister H. Hyde-White, from the School of Nursing.
S/N A. Barrett, from Cornelius Ward.
S/N R. Domaingue, from Casualty.
C/N J. Else, from William Gull Ward.
S/N S. Greaves, from Outpatients Department.
S/N J. Lyth, from Miriam Ward.
S/N G. Sawyer, from Nuffield C. Floor.

SPORT

RUGBY FOOTBALL

At a time when there is much controversy over front-row forward play which has resulted in one of the Australian tourists being sent home, it may be prudent to suggest that such occurrences are not always the fault of the offending player, but may be due to somewhat lax refereeing. Prop forwards should push in a forward direction, and not bore towards the opposing hooker, as the latter, having both arms occupied, has only one weapon to combat this pressure —his teeth! If referees allow this play of the prop forwards to continue— and admittedly it is very difficult for referees to note what is happening—further trouble will result.

Unfortunately Guy's came up against dirty play against Leicester University; this was a very poor game, and although Guy's won by 11 points to 9, the game did not do the game of rugby much credit. One of the opposition was sent off for blatantly kicking Rowlands' head. Not surprisingly, Guy's retaliated to some extent.

However, their following two matches were free from incident, demonstrating what a splendid game rugby is when played in the right spirit. Both matches resulted in good wins for the hospital by 20 points to 5 against London University, and by 25 points to 6 against Old Blues.

Unfortunately in the latter, Guy's became very lackadaisical in the second half, and only managed to score six more points to the nineteen scored in the first half, against a very slow and unfit Old Boys' side.

Guy's have scored nearly twice as many points as their opponents, which demonstrates their prowess and skill this season. With seven wins in ten matches, Guy's have by far the best record of any of the hospitals, and, although their first Cup match is two months away, such a record augurs well for their chances in retaining the Cup. Guy's have a very tough draw in the Cup, and to reach the final have to beat St. Mary's, their bogey side of recent years, in the second round, and probably St. Thomas's in the semi-final.

Unfortunately, Guy's have no fixtures for the next two weeks, but with several of the team going on the United Hospitals' tour of Scotland, they will not be short of match practice. By the time of publication, this tour will be over, as will the first Scottish trial in which Thorburn will have played. One hopes that this year he will manage to gain the cap he so narrowly missed last season.

SOCCER

After a virtually fruitless first month of the season, Guy's have at last found how to win, and a better time to start winning could not have been more appropriate—the University of London Cup. Guy's defeated Royal Free Hospital by three goals to two, and whilst still not playing at their best, this victory should be of great encouragement to the team. In the next round they come up against the strong Queen Mary College team.

Guy's continued successfully by defeating Varndean Grammar School 4—3.

HOCKEY

Guy's have continued to improve, both in midfield play and in scoring goals, with the result that they have had two more victories and one draw in the last fortnight.

They defeated Kingston Grammar School, always one of the best school sides in the country, by one goal to nothing. Last Saturday they defeated Wimbledon 2nd XI by four goals to nil, having drawn one goal each with St. Mary's Hospital a few days earlier.

With the side improving as it is, prospects for the Hospitals Cup appear somewhat brighter still; how good the side really is, one will find from their

first Cup match on November 16th, when they play Westminster Hospital. As in most sports, support is vital in Cup matches, and it is hoped that as many people as possible will be there to encourage Guy's.

SQUASH

At the time of publication, Guy's are on their Sussex tour, which, if last year is anything to go by, should be a great success.

In their first Cumberland Cup match, Guy's were defeated by 3—2 by Beckenham. This was quite a fair result as Beckenham were relegated from Division 2 of the Cup competition at the end of last season, and with Guy's being promoted to join more illustrious opponents, an opening defeat by only one match is not an unsatisfactory start.

GOLF

As already announced, Guy's have again reached the final of the United Hospitals Cup. This match will be against St. Bartholomew's Hospital at the Royal Berkshire Golf Club, on a date not yet definitely fixed, but certainly in the near future.

DIARY

SOCCER.
November. Fri., 11th—Eton Manor Strollers. Away.
Wed., 16th—Sir John Cass College. Home.
Sat., 19th—Charing Cross (United Hospital League). Home.
Wed., 23rd—University College IV. Away.

HOCKEY.
November. Sat., 12th—Gravesend. Away.
Wed., 16th—Westminster Hospital (Hospitals Cup). Home.
Sat., 19th—Surbiton 2nd XI. Home.
Wed., 23rd—London Hospital. Away.

LADIES' HOCKEY.
November. Wed., 16th—Goldsmiths' College. Home.
Sat., 19th—Charing Cross Hospital. Away.

SQUASH.
Sussex Tour, November 11th to 13th—
Friday, 11th—Brighton.
Saturday, 12th—Middleton.
Sunday, 13th—Chichester.
November. Tues., 15th—I.C.I (Cumberland Cup). Home.
Fri., 18th—Durham Light Infantry. Home.
Thurs., 24th—Escorts.

RUGBY FOOTBALL.
November. Sat., 26th—Cheltenham. Home.
Wed., 30th—Buckinghamshire County R.F.C. Home.
December. Sat., 3rd—Streatham/Croydon. Home.

*See also end of Sports Section—page 573.

REPORTS AND RESULTS

RUGBY FOOTBALL

GUY'S v. METROPOLITAN POLICE

At H.O.P. 22nd October, 1966

Result: lost 3—13

After the team's recent heartening displays against Cambridge University and Bedford, it was expected that this game might produce some exciting rugby from the home side.

As the teams trotted out on to the damp green pitch, it seemed obvious that the Guy's forwards would be tested by a huge Metropolitan Police pack. However, the early encounters revealed an enthusiastic and confident Guy's team, winning, via Kingdon, two or three clear lines-out and sorely harassing the Police when they won their set scrums. Moore, the scrum-half, and Curson were prominent in the loose. Both sides were penalised for holding or handling in loose scrums and at the second attempt the Metropolitan Police converted to take the lead.

Promptly Guy's swept up the field by means of a Right to left cross-field passing movement, followed by a superb loose heel, Morgan having been tackled by his opponent. The ball went back left to right, but the Police defence was not to be drawn and another loose scrum locked the ball.

Several times Guy's drove into the Police

"25" by means of good passing and vigorous loose rucks but their only reward was a penalty by Elliott after about 30 minutes.

From this point on the Metropolitan Police began to make Guy's efforts look ragged and ineffectual. Their scrum-half was having time to kick, pass and run without hindrance, whereas our play behind the pack was hurried and mistimed.

Half-time: 3—3

This lack of aggression was continued throughout the second half. Play swung erractically from end to end without either side gaining dominance. The Police back-row forwards, with Towers putting in a great deal of work, and the half-backs began to find defects in the Guy's defence. Twice the scrum-half ran laterally from lines-out giving his outside-half much room to move in. Twice the fly-half made sweeping outside breaks which put the Guy's line in jeopardy.

Loose possession, which Guy's had gained early in the game, was now at a premium, the back-row (with Curson excepted) being unable to arrive at loose mauls early enough.

Nevertheless, the game was still in Guy's grasp and the crowd was delighted when J. E. Davies, playing in perhaps his last game, crossed the line, following a towering cross-kick from Elliott, only to be recalled for a forward pass.

The full-back's attempted drop goal was charged down and the Police back-row hacked and pushed Guy's back to their own line. With a scrum near the right touch-line, the Metropolitan Police drew a wing-forward into the threequarter line. Guy's foolishly did not do likewise and the Police scored a good try under the posts.

The game was sealed up by another Metropolitan Police try when the scrum-half was again allowed to run across the field from a loose maul. He gave it to his fiy-half who crashed over under the posts.

So a confident and recently successful Guy's side had been suddenly shattered. Guy's had several "purple patches" in which some remarkably fine football was seen, including elegant passing, constructive well-placed kicks, clean athletic jumping at the lines-out and stirring loose rucks. But these exciting movements did not produce tries.

During these phases Guy's must score points and thus gaing complete dominance. Otherwise far too much effort will be expended in trying desperately to score the winning tries in the last few minutes.

Guy's: D. R. Elliott; J. R. M. Ross, D. J. Osborne, M. J. Cheesbrough, I. J. Morgan; B. J. Rowlands (Capt.), B. W. R. Moore; J. E. Davies, G. B. Hey, E. Neville, J. M. Cockburn, A. J. Kingdon, H. C. Sharp, C. G. Neville, D. A. Curson.

P. G. F. SWIFT

GUY'S v. LONDON UNIVERSITY

At Motspur Park November 2nd, 1966

Result: won 20—5

On a cold, windy afternoon, Guy's kicked off with the wind. Sensibly making full use of the wind Rowlands kicked long and hard downfield below the University posts;; ;not surprisingly a pair of cold hands knocked on giving a scrum to Guy's only a few yards from the University line: a quick heel by Hey, and Elliott, coming into the threequarter line, scored a good try. The conversion attempt failed. Thus, Guy's were 3—0 up after only thirty seconds.

This early setback did not dishearten the University, who had quite a good pair of halves, and quite a heavy pack. In the Guy's pack Kingdon was playing his first game as tight-head prop, having always played as a lock-forward before. A new face to the pack was that of C. Rowland, coming in as flanker in place of Curson with 'flu.

Guy's were uplifted by their early success and started to play confidently; the backs were able to practise more intricate and complex moves which more often than not did not come off as planned. However, one such move did result in a scrum near their opponents' line. Another clean, quick heel gave Elliott plenty of time to drop a goal to increase Guy's lead.

The University's attacking moves were more sporadic and usually quickly broke down due to fine tackling by the backs, and back-row forwards, of whom Sharp was playing better than he has all season.

Rowlands, who has played with more authority and composure in most games this season, was making some fine kicks to his wings, where Ross was running more determinedly than of late. After 20 minutes Guy's were awarded a penalty on the University "25" line for a scrum infringement; Elliott scored easily to give Guy's a 9—0 lead.

Soon afterwards Ross scored a fine try after an orthodox movement, with Elliott again coming into the line to make the extra man. The latter converted this try to give Guy's a commanding 14—0 lead at half-time.

In the second half Guy's were playing down the slight slope and against the wind. What chances the University outside-half had he made good use of, with some long raking kicks downwind. On one occasion when he did not kick he made a good run, evading several attempts at tackles, before scoring halfway out. This try, which should have been prevented, was converted.

However, Guy's got on top again and soon were playing with great confidence and incisiveness. The backing up of the backs by the forwards was very good, with Guy's gaining a lot of the ball in the loose. Guy's were also winning a lot of the ball in the tight scrums with Hey taking several balls against the head. The good backing up of the forwards brought a try for Cockburn after a good movement across the field by the threequarters.

However, Guy's best try was yet to come and resulted from one of their more unorthodox moves. From a scrum on the University "25", Moore passed to Ross, coming in fast inside the scrum-half, with Rowlands running to the blind side as a dummy; Ross ran hard to score halfway out. Elliott's conversion attempts to this and Cockburn's try were failures due to the strong wind.

Thus, the final score was 20—5 in Guy's favour, and a fully deserved win. It was good to see Thorburn playing again, and, although not yet fully fit, he demonstrated his speed onto the loose ball and in backing up.

Possibly Guy's could have scored more points if their attacking movements had been more orthodox, but all the same this was a good opportunity to practise more complex movements and hese may prove fruitful in future fixtures.

G. E. RATCLIFFE

Guy's: D. Elliott; J. R. M. Ross, R. J. Beacham, D. Osborne, J. Price; B. J. Rowlands, B. Moore; A. J. Kingdon, G. B. Hey, E. Neville, M. J. Cockburn, C. Neville, C. W. Thorburn (Capt.), H. C. Sharp, C. Rowland.

CROSS-COUNTRY

Although the Cross-Country Club started the season with some new names from the freshers, and the welcome addition to its

ranks of Dave Halestrap, there is still a shortage of active members. During the summer the club was granted autonomy within the Clubs' Union, and it would be a bad reflection if enough vital interest could not be summonsed to justify our separate existence. We extend a sincere welcome to anybody who wishes to take part in this very individual brand of sport.

The first match of the season on October 12th, was against Latymer School over their 4½-mile course at Hammersmith. Guy's won easily by 12 points to 24:

1st, R. M. Wilson; **2nd,** B. Smith; **3rd,** J. Harrild; **6th,** A. Thompson.

On the following Saturday, Guy's competed in University College's annual invitation 6 x 1.6 miles relay at Parliament Hill Fields. This has now become a very popular fixture and attracts teams from outside London. Nottingham University won the team title, and M. Tagg, of Reading University, set up a very fast lap record of 7 mins. 40 secs. Guy's finished 38th out of 45 entries.

B. Smith, 9 mins. 10 secs.; H. Robertson-Ritchie, 11 mins. 24 secs.; R. Wilson, 9 mins. 32 secs.; D. Choat, 9 mins. 36 secs.; D. Halestrap, 9 mins. 45 secs.; J. Harrild, 9 mins. 56 secs.

Guy's returned to Parliament Hill Fields on Wednesday, 19th October, to compete in a triangular match against the Royal Veterinary College and the London Hospital over a 5½-mile course. Jeff Harrild, a fresher, showed his earlier promise by some good front running during the course of the race. The fact that we did not have a complete team unfortunately placed us in 3rd position behind R.V.C. and the London.

4th, B. Smith; 5th, J. Harrild; 8th, R. Wilson; 15th, E. Bowen-Jones.

R. M. WILSON

HOCKEY

GUY'S v. KINGSTON GRAMMAR SCHOOL

At Thames Ditton: Saturday, 29th October
Result: won 1—0

It might be thought that a school side would provide inadequate opposition for the Hospital 1st XI. However, in the case of Kingston Grammar School this is not so, for this school is probably the best in the country, being somewhat exceptional in that it plays the game in both winter terms, and is fortunate in always having ex-hockey internationals on the staff whose coaching is reflected in its high standard of play. It is always, therefore, a game which Guy's approach with particular determination, and this year their resolute and energetic play paid due reward earning them a 1—0 victory.

Dodd scored a characteristic opportunist goal following up a rebound off the goalkeeper's pads, but it was Cripps who was the outstanding forward of the day. He fought with tremendous fire and vigour and succeeded in the difficult task of "crossing" the ball time and time again from the left wing. He was well supplied by Appleby, the captain, who has made a successful switch from centre-forward to inside-left this season and who continues to set a fine example to his side this season with his talented play. Finally, mention should be made of Nick White who had an excellent game in goal and visibly gains confidence in every successive game.

This very encouraging result augurs well for the Cup.

J. K. CRAFTS

GUY'S v. ST. MARY'S

At Teddington. Wednesday, 2nd November
Result: drawn 1—1

In an uninspiring match Guy's drew with St. Mary's at Teddington. For the first time this season the Guy's 1st XI did not give 100 per cent effort. During the first half the defence were lazy in covering and failed to use the ball to good effect.

Late in the first half Mary's scored from the left when the wing broke clear and placed a back-of-the-stick shot in the corner of the net.

The second half saw an improvement in the side; Appleby's half-time speech having its usual effect. Guy's now looked as if they should score, and when they did it was through a piece of fine team hockey. Vellacot gave Appleby a long diagonal pass which put him clear of the half-backs. Appleby then beat backs, drew the goalkeeper out and centred the ball. Cripps, using his new-found speed, came up to finish off the movement with a first time shot.

Time was then played out without either goalkeeper being tested, and Guy's were left feeling that they should have won but had nobody to blame but themselves.

Team: D. Ryland; M. Vellacot, D. Crafts; M. Horrocks, V. Harvey, R. Kendrick; A. Brooks, H. McMichem, N. Dodd, M. Appleby (Capt.), S. Cripps.

R. W. KENDRICK

GUY'S v. WIMBLEDON 2nd XI

At H.O.P.. Saturday, 5th November, 1966
Result: won 4—0

Continuing their recent run of successes, Guy's recorded a very creditable victory against Wimbledon 2nd XI. This is a new block fixture and the measure of this Club's strength can be ascertained by the fact that their 1st XI beat Cambridge University on the same day.

Guy's started off a little shakily but their game settled down when they saw that they were superior both in speed and skill. The first goal came just before half-time after Dodd collected a penetrating pass from the left-wing and bounced the ball over the goalkeeper's kickers!

After half-time the team really worked well together—the defence distributing the ball skilfully to the forwards, who in turn cut decisively through the opposition defence. The second goal came from Appleby after a good centre by Brooks, and very soon after Dodd brilliantly converted another hard centre from the right.

Fortunately Guy's did not take their customary rest and, egged on by a female supporter who kept a continual supply of balls on the field (sometimes two at a time!), managed to maintain the pressure.

Despite the fact that Cripps and Appleby worked well on the left wing, it was left to Pearson, the left-half, to force his way through and sneak the ball between pads and post for the fourth goal.

All in all this was an excellent performance, and it is to be hoped that Guy's can maintain this standard for the first round of the Cup next week.

Team: N. White; M. Velacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, H. McMichen, N. Dodd, M. Appleby, S. Cripps.

S. CRIPPS

SOCCER

GUY'S v. ST. THOMAS'S HOSPITAL

At H.O.P. 19th October, 1966
Result: lost 8—4

This match saw the start of the Inter-Hospitals' League. Guy's took to the field with a good team on paper. The game was a fair reflection of the team's capabilities, and gave clear indications as to what should be worked on.

The first half showed the weakness of the defence, six goals being conceded. Although there was a visible pattern of play, the system was too square, the majority of goals coming from inside the six-yard box.

The second half brough about an improvement and the attack came more into the game scoring three goals, but even so four good chances were missed. Thomas's were fortunate to have a very capable goalkeeper, who saved well from several shots.

It is a pity that this game was the first of the league matches because generally every player had a good individual performance, although though there was no co-ordination as a whole. If the lessons of this game are taken in and the style of play altered accordingly, the team will play a prominent part in the league championship.

Team: M. Carter; R. Davey, S. Watt-Smith; S. Poole, I. Nash (Capt.), R. Lovell; S. Jacobs, D. Lindridge, D. Ward, E. Elias, T. Dutta.

Preliminary Round—University Cup

GUY'S v. ROYAL FREE HOSPITAL AND SCHOOL OF PHARMACY

At H.O.P. 29th October, 1966
Result: won 3—2

The match began, on a rather bleak afternoon, with Guy's first into the attack, commendable efforts by Lindridge and Poole being turned aside. Gradually, however, the opposition came more into the game and the still unsettled defence allowed a simple goal. A good break and centre by the opposition's left-winger found one of their forwards unmarked on the penalty spot and it was a simple task for him to put it passed the 'keeper.

Guy's strugged on. The passing was of a poor standard throughout the team. Five minutes before half-time the defence again slipped and the opposition scored.

Half-Time: Guy's 0, Royal Free 2

Guy's kicked off again, and soon afterwards Dutta did well to run on to a through ball, riding a strong tackle by the centre-half and continued towards the goal. The goalkeeper tried to smother the ball, but Dutta scored for the Guy's first goal.

This early goal brought heart to the team, especially as the opposition appeared to be tiring and Guy's played with more intent. After twenty minutes constant pressure and good football, Guy's scored with a superlative goal from Poole who ran on to a loose ball, hitting it first time from 15 yards, and sending in a well placed shot which curled away from the goalkeeper.

Guy's continued to play attacking football, and had much of the play. With ten minutes to go Guy's forced a corner on the left, from which Jacobs centred to Lindridge who, with a spectacular overhead kick, managed rather luckily to find the net and give Guy's the winning goal.

This was a very satisfying result and shows that the team can fight back from 2—0 down to win.

Team: M. Carter; R. Davey, S. Watt-Smith; R. Lovell, P. Evans, I. Nash; D. Jacobs, S. Poole, T. Dutta, D. Lindridge, J. Allen.

M. WATSON

GUY'S v. VARDEAN G.S.

At Brighton. 2nd November, 1966
Result: won 4—3

Vardean kicked off on a cold, windy day and set up some early pressure in the Guy's half. The Hospital were having the usual troubles of bad marking and poor passing, allowing the opposition to score an early goal. The rest of the half was equal with the sides playing scrappy football.

In the second half, with the wind more or less behind them, Guy's became more dominant. However, soon after the restart Davies succumbed to a "pulled hamstring" and changed the centre-forward spot with Jacobs. This turned out to be a good move, and Jacobs scored three well taken goals. The visitors played with more verve and co-ordination, but the defence again slipped and allowed the School to score again. However, through the wizardry of Lindridge, Guy's went further ahead when he beat the defence twice over and his shot trickled just inside the post. Vardean scored again just before time to give the final result.

Team: M. Carter; R. Davey, S. Watt-Smith; R. Lovell, P. Evans, I. Nash;; W. Davies, S. Poole, D. Jacobs, D. Lindridge, J. Allen.

I. T. NASH

GUY'S v. U.C.H.

At H.O.P. 5th November, 1966
Result: won 2—1

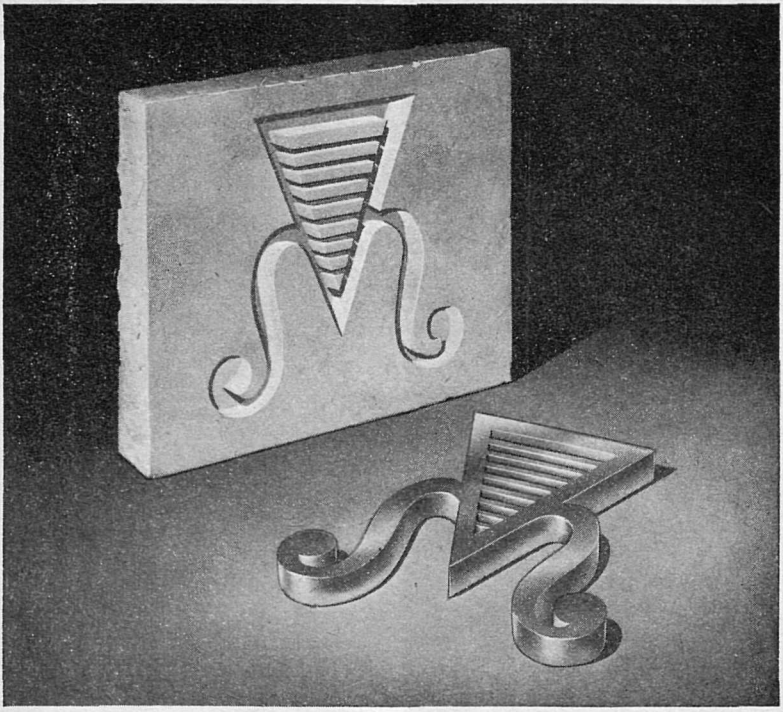
This match was intended to be a league fixture, but as there was not a qualified independent referee, it was decided to play on a friendly basis.

The Guy's team played quite well, often finding their own men with some good football. However, as so often has been the case, the opposition opened the scoring. After half-time the Guy's team was completely dominant and should have been three or four goals up, except for poor shooting. It was left to Poole to show the rest of the forwards to way to the net, and he scored two goals to give Guy's victory.

Most of the home team seemed to be out for an afternoon stroll, but on considering that it was after the Dental Ball, and several players had only just got up before the kick-off, the result was pleasing.

Team: J. Wood; P. Epps, S. Watt-Smith; R. Lovell, R. Davey, I. Nash; D. Jacobs, S. Poole, T. Dutta, D. Lindridge, R. Leeburn..

I. T. NASH



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References:
1. Meffert & Hoskins: J. Periodont, 35:232-35 (May-June) 1964. 2. Zelman & Hillyer: New York J. Dent 33:259-62 (Aug.-Sept.) 1963. 3. Skurnik: J. Periodont, 34:183-185 (March) 1963. 4. Cohen: Oral Surg., Oral Med., Oral Path. 14:1046-52 (Sept.) 1961. 5. Ross: J. Periodont. 32:49-53 (Jan.) 1961.

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SPORTS DIARY—Addendum

BOAT CLUB

November.

Wed., 16th—The United Hospitals' Regatta. This will be held at Chiswick and Guy's will be strongly represented. Racing goes on from 10 a.m. until 4 p.m.

Sat., 26th—The Hospitals' Boat Race between St. Bart's and Guy's. There will be two divisions, the senior of which is for the "May and Baker" Challenge Cup and the Junior Division for the "World Medicine" Challenge Shield.

December.

Sat., 3rd—University of London Winter Eights Regatta will be held at Chiswick.

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL AND SOUTH-EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Applications are invited to fill an established vacancy for the appointment of **Senior Registrar in Psychological Medicine to the Board of Governors of Guy's Hospital and the South-East Metropolitan Regional Hospital Board.** The appointment will be for the period 16th January, 1967—30th September, 1968, with duties until 30th November, 1967, at Guy's Hospital and for the remainder of the appointment at St. Olave's Hospital. The post, which will be reviewed annually, is subject to the Terms and Conditions of Service Hospital Medical and Dental Staff (England and Wales). Forms of application are obtainable from, and should be lodged with, the Superintendent, Guy's Hospital, S.E.1, not later than **30th November, 1966**.

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for a post of **Senior Lecturer or Lecturer in Histology/Cytology in the Anatomy Department.** Salary range: Senior Lecturer £2,520 to £3,255 or Lecturer £1,895 to £2,630 plus London Allowance, with superannuation; initial salary according to qualifications and experience. Application should be made on a form obtainable from the Dean, Guy's Hospital Medical School, London Bridge, S.E.1.

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the post of **Full-time Lecturer in the Department of Dental Prosthetics**. Salary in the scale £1,580 x £110 to £1,690 x £115 to £2,150 x £110 to £2,480 x £55 to £2,535 with superannuation. Duties to commence as soon as possible. Forms of application are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Monday, 28th November, 1966.**

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BIRTHS

GUNN.—On 28th September, 1966, to Elizabeth (née Chiesman) and Andrew Gunn a son, Neil Alexander Livingston.

MORTON.—On October 23rd, 1966, to Shirley (née Young) and Oswald Morton, M.B.B.S, a son, Jeremy Spencer, a brother for Nicola.

SHEARD.—On 12th October, 1966, to Julia (née Geidt, S.R.N., S.C.M.) and Peter Sheard, of Stroud House, Freshwater, I.W., a daughter, Emily Margaret, a sister for Rupert.

WILSON.—On 24th September, 1966, at Hereford, to Irene (née Wallace, S.R.N.) and Derek Wilson, M.B., B.S., D.R.C.O.G., a son, Nicolas Adam, a brother for Louise and Timothy.

MARRIAGES

BLUNDELL—LINFIELD.—On September 14th, 1966, at Rustington, Sussex, Dr. Grahame E. Blundell to Patricia I. Linfield, S.R.N.

HEALY—SHEPPARD.—Thomas E. J. Healy, M.B., B.S., B.Sc. and Lesley E. Sheppard, S.R.N., H.V., on 3rd November at Westminster Cathedral. The Rt. Rev. Monsignor G. A. Tomlinson, M.A., blessed the wedding, and Rev. Fr. Frazer gave a short address. A papal blessing was received.

MURRAY—NEEDHAM.—On 3rd September, 1966, at St. Cuthbert's Church, Hove, Sussex, Dr. Brian R. P. Murray, M.B., B.S., F.F.A., R.C.S. to Vyvyan M. Needham, S.R.N., S.C.M.

TAFT—LANE.—On October 1st, at St. Mary's Church, Ewell Village, Surrey, Lieutenant George Taft (U.S.A.), to Christine Lila Lane, S.R.N., S.C.M.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

GUY'S HOSPITAL GAZETTE

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2044

PASSIM

End The Weak End?

The Albany Medical Centre in New York recently published the results of an experimental year of remaining fully functional throughout the week-end and revealed that by this simple, and in so many ways obvious, measure, the hospital had given medical service to nearly a thousand more patients and had effectively increased its bed-strength by 30.

This sort of change was effected by staggering the normal week-end, so that everyone still had their days off, but at different times, and so that the Clinical Pathology, Pharmacy, etc., remained functioning every day of the year. In some departments it must be admitted they did not manage this completely but the final outcome was an economy of time and an increased efficiency that begs to be copied elsewhere.

Everyone who has worked in a hospital at week-ends knows just what a nuisance is caused by the absence of the normal routine, especially the loss of the usual ancillary services. So far no evidence exists to show that any disease or even one obscure strain of bacterium rests on the Lord's day and until this is forthcoming it is obviously both illogical, and in some instances quite frankly dangerous, not to have every branch of the medical service that is thought necessary for a Wednesday being equally available on a Sunday. For time is wasted when an overworked skeleton week-end service has to play around trying to find the proper tools for the job. Time and money is wasted when people are admitted to hospital and have to hang around until they can be operated on or seen by the appropriate consultant. Time, money and ink is wasted when traditions fostered by mental arthritis over-ride all suggestions for change. And in the end it is the patients that suffer.

Of course, week-ends are potentially excellent institutions for two days' rest and enjoyment, but they are currently a vulgar and herd-like scramble when the entire country downs tools en masse in deference to a religion it no longer practises. For those working in essential services like Medicine there should be no such hypocrisy; the job should come first and the days off be adjusted according to the need of providing the best possible service at all times.

This is of course true, but nothing will be done for fifty years.

Pre-registration

It began as one would expect, in a situation of adversity. The progress was classical. A governmental Inter-Departmental committee produced its report (Goodenough, 1944) on the formalization of the pre-registration year, and classically again it took a mere ten years for its implementation. By which time it was partly outdated. Duly three years later the Deans' Conference provided the modifications. The inevitable finale arrived in 1964 when the Association for the Study of Medical Education revealed the gross shortcomings of plan and current practice.

Thus the role of further and practical education of the newly-qualified doctor has been instituted, practised and ignored in the obligatory pre-registration year. On the whole a useful, if not essential maturation period of undergraduate learning is with us. Its variations, from provincial large general ward Scylla to teaching hospital small specialized ward Charybdis bring their inherent difficulties of preference. For Goodenough stressed that the prime purpose of the year should be educational.

The year in the teaching hospital has the paper advantages of better educational environment and general diagnostic and therapeutic facilities. The very real disadvantage is the wasting of money and brains in that the houseman, with so many above him in the firm, runs the danger of his responsibilities being overwhelmingly clerical rather than medical or surgical. With admirable drive and impatience, however, the Guy's residents have instituted for themselves a weekly luncheon seminar, with talks from their medical superiors. It is a good beginning, but let it be remembered that that is what it is. The opportunities, however, are limitless. Friday Combined Rounds tend to combine little more than students, a few housemen, registrars, fewer consultants than patients and a few visitors, while the monthly Clinico-Pathological Conferences combine a surgeon or two, a student or three, a few pathologists and, of course, visitors. Someone says there was once a Radiology Conference; surely there are not many others that have escaped our attention, or else they are unenviably clandestine exercises. There seems to be little combining of sectors which are not almost already one.

The calls come out in profusion—Topic Teaching, Combat Over-Specialization, increase the length of the pre-registration year(?), etc. etc. The *Lancet* has eulogised, the B.M.A. pontificated, and criticism flourishes in a paucity of corrective action. We know by heart "the more we know, the more there is to know". While another Royal Commission has occupied the well-worn armchairs, it is pleasing to note that someone somewhere is doing something constructive.

Miss Sidney

In this issue we are printing an appreciation of Miss Sidney by the late Mr. J. C. Carlisle. Miss Sidney is well known to many generations of Guy's men, especially those who knew her when she was manager of the *Gazette*; we previously printed a tribute to her in the issue of 27th January, 1962, when she retired from the *Gazette*. This time she has retired from all formal connections with the hospital and the present Editors would like to add their thanks to her again on behalf of the *Gazette* and they hope she will have a full and happy retirement.

GUY'S DIARY

NOVEMBER—Exhibition: Urethral Catheters (in Gordon Museum)

26th	Sat.	10.00	Clinico-Pathological Meeting: In the Clinical Theatre.
28th	M.	1.00	Clinical Lecture. Mr. BATCHELOR. "Some Cases of Orthopaedic Interest".
29th	Tu.	1.00	Clinical Lecture. Mr. CLARKSON. "Toe-Hand Reconstruction of the Thumb".

DECEMBER

1st	Th.	1.00	Clinical Lecture. Mr. LAWRIE. "The Acute Abdomen in Childhood".
		4.30	Physiological Society. Mr. K. SOMMI. "Heroin Addiction".
2nd	F.	1.00	Clinical Lecture. Dr. ABRAMS. "The Analytical Engine: An Introduction to Computers".
		2.15	Combined Round. Dr. HART (Westminster Hospital).
5th	M.	1.00	Clinical Lecture. Dr. MARY SHERIDAN. "The Development of Communication in Young Children".
6th	Tu.	1.00	Clinical Lecture. Dr. SAXTON. "Disorders of Swallowing and of the Oesophagus".
8th	Th.	4.30	Physiological Society. Mr. R. SAVAGE. "The Flouride Problem".
9th	F.	1.00	Clinical Lecture. Mr. BRAIN. "Mediastinal Tumours—II".
		2.15	Combined Round. Prof. COHEN and Dr. BARKHAM.

THE CARCINOID STORY

By
A. Kumar

In the last decade much was written about a syndrome which students and doctors take great delight in spotting. This is the Munchausen Syndrome, named after the Baron Von Munchausen. These people (like the Baron) are widely travelled hospital patients or "visitors" with dramatic and false symptoms, often characterised by abdominal scars. Similarly the carcinoid tumour will test any clinician's incredibility. It was suggested by McKusick (of Johns Hopkins) that the symptoms produced in a patient with carcinoid tumour be given the name of Jules Verne Syndrome; for its component manifestations will outstrip even the wildest dreams and show that truth is stranger than fiction.

WHY CARCINOID?

In retrospect review of literature the credit of describing the first case is given to Lubarsch in 1888. This was at post-mortem and he labelled the pathological tissues as "Little Carcinomata"—columns of cells with pseudoglandular formation. He implied that this pathological tissue was a variation of carcinoma. It was left to Oberndorfer (1907) to give the name carcinoid to this pathological tissue as an indication of its benign nature. But, as will be seen, this was an unfortunate error, since many of these tumours are clearly malignant, and resulted from studying carcinoid tumour from the appendix, where the behaviour differs from tumours elsewhere.

SITES

The tumour is commonly found anywhere from the cardia to the rectum, the appendix being a common site. About 90 per cent of appendix tumours are carcinoid. These tumours are less commonly found outside the gastro-intestinal tract, in the lung, ovary, pancreas and gall bladder.

ORIGIN OF CARCINOID TISSUE

In 1912, Saltykow suggested an association of carcinoid tissue cells with those in pancreas as both cells contain granules. This theory of origin was rejected, as the carcinoid cell granules were chromaffin (cells which stain yellow with chrome salts) unlike the pancreatic cells.

Independent of the above controversy, a new cell was discovered in the intestinal epithelium by Kulchitsky. This cell in the crypts of Lieberkuhn also contained granules which could be stained yellow (known as yellow cells, by Schmidt). They were labelled as enterochromaffin cells or yellow cells of the intestine.

To confuse the issue, another view was dominant in the minds of pathologists regarding the carcinoid tumour; that it arose from the adrenal cortex. This view was based on the superficial resemblance of both cells in containing fatty inclusion bodies.

By about 1920, the abscess was pointing, ready to be incised by the Jules Verne of this story—Pierre Masson.

PRESENT VIEW

Masson demolished the adrenal cortex as origin of the carcinoid cell on logical deductions. He noted the resemblance of the carcinoid cell and adrenal cortex on microscopy; on staining with Iron Haemotoxylin the carcinoid granules turned black, like those of adrenal medulla. Since the adrenal cortex and medulla are embryologically, anatomically and functionally different, the carcinoid cell cannot arise from either source and yet resemble both.

Masson then studied the effect of staining carcinoid tissue with ammonium silver nitrate. The carcinoid granules stained brown, indicating the property of silver reduction. Adrenal cells did not furthermore show this. On staining the intestinal wall, the cells of Kulchitzky stood out with the silver reduction property. Accordingly, Masson concluded that carcinoid tumour arose from a proliferation of the silver reducing cells of Kulchitzky (Argentaffinoma). He postulated further on histological grounds that these cells were a diffuse endocrine gland.

SEROTONIN

A few years later, Erspamer and Vialli published a classical paper showing the isolation of a substance—enteramine from rabbit intestinal mucosa. They showed that enteramine was abundant in the carcinoid tissue. Enteramine is the specific secretion of carcinoid tissue. In the late 1940's enteramine was shown to have the structure of 5-hydroxytryptamine (serotonin) (Rapport, Fischer, Green, Hamlin).

Hence, by the early 1950's, it was clearly established that a carcinoid tumour occurs in the alimentary tract which may contain or produce excess serotonin. Most of the carcinoid tumours were never diagnosed in life. They were found at autopsy or on laparotomies for intestinal obstruction of unknown cause.

A SYNDROME

In 1953, Isler and Hedinger reported from Zurich three cases of carcinoid of the small bowel. In these cases, there was extensive metastasis to abdominal organs, chronic endocarditis of right side of the heart and pulmonary stenosis. They all had severe cyanosis. Such a case had been published already in 1931 by Scholte. It was left to the Zurich workers to express the belief that the whole clinical picture was a "Symptom Komplex". Separately, the Swedish workers at Malmo (Thorson, Biorck, Bjorkman and Walderström) came to the same conclusions. They reported what is probably one of the early cases of carcinoid to be diagnosed pre-operatively. The principal findings in their cases were carcinoid of small intestine, metastasis to the liver, diarrhoea, abdominal pain, vasodilation of the skin, plethoric colouration, pulmonary stenosis, tricuspid incompetence and bronchial asthma.

Work by Reid, Rand and Page lead to the common link between the carcinoid tumour and its manifestations—5 hydroxytryptamine (serotonin). This opened a new field for research, the studies on the metabolism and properties of serotonin in the body, and its correlation with the manifestations of the carcinoid syndrome.

CARCINOID vs. CARCINOMA

Both these pathological conditions are neoplastic and may exhibit metastasis at distant sites, via blood or lymphatics. In the appendix, however, the carcinoid tumour tends to be a solitary, slow-growing, yellow mass with few mitoses. The tumour appears to take a long time to metastasize. Elsewhere these tumours appear to be more malignant and metastasize to a wide variety of organs. Thus carcinoid tumours are not benign as the name suggests. Hence Willis suggests that these tumours should be called Argentaffin or Kultschitzky cell carcinomas.

SEROTONIN METABOLISM

Serotonin (5-hydroxytryptamine) is a naturally occurring biologically acting amine formed from tryptophan. Serotonin is oxidised to 5-hydroxyindole acetic acid which is an inert substance excreted in urine. This breakdown requires monoamineoxidase.

The alimentary tract contains over 80 per cent of all serotonin in the body. Other sources are platelets (probably obtained from intestine) and central nervous tissue. Bananas are rich in serotonin.

TABLE I.

Normal Values

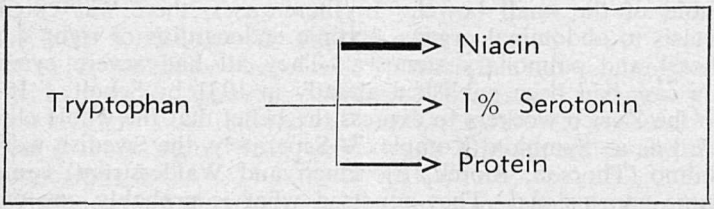
—Blood serotonin level = 0.1—0.3 microgram/ml.
—Urinary excretion of 5-hydroxyindole acetic acid = 2—10 mgm/24 hours.

In Carcinoid Patients

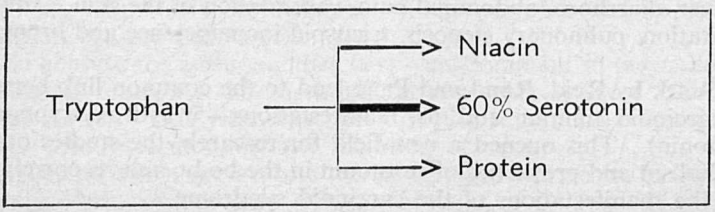
—Blood serotonin level = up to 3 microgram/ml.
—Urinary excretion of 5-hydroxyindole acetic acid = up to 400 mgm/24 hours.

METABOLIC CHART

Normal Pathway



In Carcinoid Patients



CORRELATION OF SYNDROME TO EXCESS SEROTONIN

Features of the syndrome are :

1. Vasomotor disturbances—flushes, patchy cyanosis, hypotension, sweating.
2. Abdominal disturbances—diarrhoea (sudden watery stools), intestinal colic, borborygmi, hepatomegaly with secondary lesions, intestinal obstruction, gastrocolic fistula.
3. Respiratory disturbances—cough, wheezing.
4. Cardiac disturbances—pulmonary stenosis, endocardial fibrosis, tricuspid incompetence. In many of the case reports published, these disturbances are asymptomatic. They are usually diagnosed on auscultation.
5. Cutanous disturbances—pellagra-like skin—hyperkeratosis and pigmentations.

Some of the features can be explained by :

(a) direct pharmacological effects of excess serotonin

Hyperperistalsis leading to diarrhoea

Bronchoconstriction leading to wheezing

Both vasomotor and cardiac manifestations are still largely unexplained; Levine and Sjoerdsma report that use of vasopressors (e.g. nor-adrenaline) in patients with carcinoid tumour produce a paradoxical hypotension.

(b) Niacin deficiency

Tryptophan metabolic studies show in carcinoid patients that this defect occurs (see chart). The deficiency is enhanced in carcinoid patients by the diarrhoea.

Niacin deficiency may explain the pellagra skin.

Recently it was found that some carcinoid tumours produce substances other than serotonin. These include 5-hydroxytryptophan (precursor of serotonin), histamine and bradykinin. Carcinoids of the bronchus in particular produce some of the above substances.

There is very little experimental evidence for the mechanism of endocardial and valvular fibrosis. The predisposition for the right side of the heart may be explained by the high concentration of serotonin released by liver metastasis. Right sided lesions also occur when the primary carcinoid tumour can by-pass the liver, e.g. ovarian teratomas. The high content of amine oxidase in the lung appears to protect the left side from the effects of serotonin. Left side of the heart may be affected with a patent foramen ovale, where the tumour is present in the lung (and therefore not broken down) or where the lung fails to detoxify due to excessively high concentration.

The carcinoid syndrome may appear in other conditions as well. It has been associated with scleroderma, bronchial carcinoma, pancreatic carcinoma and Cushing's syndrome (adrenal hyperplasia).

SEROTONIN ANTAGONIST

On the assumption that carcinoid syndrome is due to excess serotonin the natural line of research was to discover antagonists.

Gaddum first reported that lysergic acid diethylamide (L.S.D.) blocked the stimulant effects of serotonin on smooth muscle. Deseril (lysergic acid derivative) retains the antagonistic properties of L.S.D., while losing the hallucinogenic effects. But this drug appears to reduce the diarrhoea only in carcinoid patients.

CONCLUSION

An attempt is made to trace the main events in the development of the knowledge in the carcinoid syndrome. P. Masson is a key figure who, in 1928, established the origin of the carcinoid tumour. Independently, enteramine was isolated from carcinoid tumour and its properties studied. In the late 1940's enteramine was shown to be serotonin. In 1953 came the first reports of a clinical syndrome—the carcinoid syndrome. However, the correlation of serotonin to the syndrome is incomplete. One likely explanation is that the carcinoid tumour may be secreting other substances than serotonin, as serotonin antagonists do not abolish all the features of the syndrome.

Sjoerdsma and Melman suggest that the vast knowledge accumulating about carcinoid disease poses a spectrum of clinical conditions rather than a single syndrome. The carcinoid tumour should be considered as having multipotential endocrine properties. The carcinoid tumours arising outside the gastrointestinal tract do not seem to fit the classical picture.

ACKNOWLEDGMENT:

I would like to thank Dr. R. W. R. Archibald, Department of Morbid Anatomy, for reading and correcting this manuscript.

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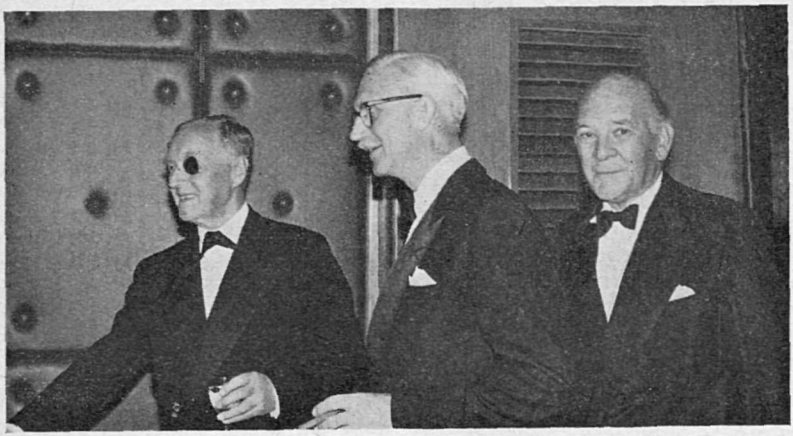

Sir Rowan Boland, Dr. Houston and Mr. Eckhoff, at the Biennial Dinner.

MISS SIDNEY

The retirement of Miss Sidney as Secretary of the Guild of Ex-patients and Friends of Guy's Hospital, brings to an end an epoch which dates back to 1920 when she joined Guy's to assist the late Mr. Homfray, then starting an appeal office. Very soon her outstanding gifts were apparent, and when the Guild was formed in 1933, her initiative brought an ever widening interest by ex-patients and friends in its work to provide funds for the comforts of patients in hospital. Later with the steadily increasing membership it has been possible within our constitution to extend the Guild's work; to contribute to research projects, comforts for nurses and other staff, and as a special contribution to assist in refurnishing as the hospital is rebuilt

Over the war years, Miss Sidney's personal efforts kept the Guild alive, and contributed aid for patients as far as conditions permitted.

Then in 1948, when the Guild was faced with survival only if it became entirely self-supporting, Miss Sidney courageously met the challenge, and with her fine organisation, the work quickly went ahead. The strength of her leadership reflects the established position the Guild enjoys to-day—a sound financial position and at least eighty to ninety thousand pounds expended for the benefits the Guild stands for—a proud record to which can be added that never has any request from the Hospital within the Guild's capacity to provide, been refused by Miss Sidney.

I can speak for all who have been privileged to be associated with Miss Sidney over the years when I express our great appreciation for her work.

Happily as a life member of the committee, we shall continue to have the benefit of her advice and inspiration which we earnestly trust will be for many years ahead.

This appreciation was written by the late Mr. J. C. Carlisle, who was a member of the Guild from 1938 and its Honorary Treasurer from 1956 until his death earlier this year.

MISS ADDISCOTT — a tribute

from a former member of her staff

1920—The House Committee permitted the title of "Almoner" to be used by Miss Beardoe-Grundy, and the Department to be known as "The Almoner's Department".

1927—On the resignation of Miss Beardoe-Grundy, Miss Addiscott was appointed Almoner, at a salary of £350, raised in 1930 to £400.

1952—Miss Addiscott retires.

1966—Miss Addiscott died in August.

These may sound bald statements but, in fact, this little span of years contained significant development in the social services and in our own Department at Guy's.

What sort of person was Miss Addiscott and what was it about her that made an impact? Economy of words—speed and precision that would spark even the dullest mind to swift reaction, if only to recede from sight as fast as manners permitted and repeat slowly to oneself the words till they again made sense—and what sense they made! A quickness of wit—an agility and directness of mind—yet undemonstrative— uncomplicated for a woman—she shrank from any form of excess.

She had, as we thought, a rather intolerant conception of incompetent women who traded on their charm—"fit for nothing but matrimony" was once rapped out to our consternation as some pretty but particularly fatuous bird-brain was dismissed from her presence, and "what she is pleased to call her mind" about a troublesome and obstinate mother engaged in an argument from which she emerged demolished. A colleague writes of her: ". . . she had an exceptionally quick, clear brain, and though her voice was always kind and gentle, she would make astringent and amusing comments to her assistants. She trained many almoners and considered that one of their aims should be to show 'sympathy without sentiment'. The door of her office was rarely shut and there was a constant stream not only of patients, but of people from the Borough dropping in to tell her the family news, the medical staff, Sisters and people from other departments of the hospital. She never appeared hurried and welcomed everyone. To a trainee she said, 'Don't walk about looking so busy.' Her capacity for work was enormous, and when the office closed in the evening she often went on to committee meetings of local charitable organisations. She relaxed by listening to music, working in the garden of her country cottage, or by travelling in Europe."

Miss Addiscott's methods of work were remarkably far-seeing and in advance of her time, utilising to the full the main sources of help available from specialised agencies in the community. She was tireless to ensure the patients' freedom of choice when once they had understood the doctors' advice and possible consequences of disregarding it. No pressure was brought to bear, and a patient "need have no fear that his freedom of action will be interfered with or that a host of unsolicited visitors will be launched on him in his home. . . . In this connection a question naturally arises, viz., how to safeguard patients from incompetent social service." She continues, ". . . The modern Almoner still has to cope with the effects of the old tradition that indiscriminate charity with its comfortable glow of self-satisfaction to the donor is a meritorious act. The social conscience is gradually awakening to the fact that to help a fellow creature is the most difficult and responsible task that a human being can undertake, and with this awakening has come the recognition of the necessity for highly specialised training for Social Service. Above all, the fact must never be out of our minds that every social failure, individual or collective, is a symptom of social disease. A Hospital Almoner, of all social workers, should recognise that, though the alleviation of acute symptoms may be too urgent to brook delay, it is the primary disease that must eventually be attacked and conquered if any real progress is to be made."

These words were written in 1923 when social service as we now know it was growing out of the concept handed to us by the great early voluntary organisations.

But Miss Addiscott had a second interest, as important to her as the work of the Department, and this was the training of her assistants in the discipline and principles of social work. Her purpose was to send them out fully equipped into the profession. Many who passed through her hands have, in fact, succumbed to marriage, and with her blessing in spite of her disparaging observations. Others completed the Emergency war-time course offered by the then Institute of Almoners.

The Second World War provided scope for her to come to grips with a new challenge, the force of which dominated her horizon and inspired those of us who worked with her. She organised an emergency air-raid team living in Guy's and worked untiringly throughout the war, carrying the routine office duties at the same time.

At the end of the war she was beginning to slow down a little. In 1952 she decided to relinquish her post and she retired. Guy's filled her life for 32 years—countless people benefited by her work and were influenced by her stature and unselfish devotion to humanity.

MARY E. STEEL

NOTICES

Christmas Concert

The Concert will take place on Wednesday, December 7th, at 8 p.m., in Southwark Cathedral. Programme:

Vivaldi—Concerto for 2 trumpets.

Britten—Ceremony of Carols.

Handel—Coronation Anthem: "Let thy hand be strengthened."

Handel—Organ Concerto, Op. 4, No. 4 in F.

Handel—Coronation Anthem: "Zadok the priest."

Admission by programme on sale at the door.

A silver collection will be taken in aid of the work being done by Dr. Philip Evans, senior paediatrician at Guy's Hospital, and his team, at the Nhi Dong Children's Hospital in Saigon.

N.B.—The choral works will be repeated the following Tuesday, December 13th, in St. Paul's, Knightsbridge. There will be a dress rehearsal for the Christmas Concert in Southwark Cathedral at 6.30 p.m., on Tuesday, December 6th.

Music Circle

Tuesday, 29th November—Stephen Walsh, music critic (lately of the *Daily Telegraph,* now on the *Observer*) will talk on "Elgar: romantic genius or imperial pamphleteer?"

We are very lucky to have been able to persuade Mr. Walsh to come. It is hoped that everyone interested in music will make a big effort to attend.

Guy's Hospital Table Tennis Club A.G.M.

The A.G.M. of the Table Tennis Club was held at 5.15 p.m. on Monday, 24th October, in the Anatomy Theatre. K. E. Pringle, F.D.S., R.C.S., L.D.S., took the chair. The following committee was elected:

Honorary Secretary—K. Taylor.
Treasurer—P. Bennett.
Fixture Secretary—B. Levy.

I. Learner was also appointed to the Committee. The Table Tennis Club is fielding four teams in the U.L.U. Leagues this year, in addition to both "Ladder" and "Knock Out" competitions.

A successful season is hoped for.

THE COMMITTEE.

CORRESPONDENCE

The Dental Curriculum

SIR,—The article on the dental curriculum by Mr. Wilton is most interesting, and equally disturbing. He has only just qualified and has yet to be immersed in the frustrations of the general practitioner in the Health Service.

What disturbs me as a Guy's graduate is the almost alarming reduction in the quota expected of the student whilst learning the complex advanced operative techniques.

One cannot help wondering if this is a deliberate move to produce a graduate more suited to the amalgam/silicate class of N/H conservation.

If so this is a retrograde step. Now we have just had the General Dental Council report on dental auxiliaries published, enthusiastically supported by the B.D.A., the future of the dental practitioner is, to put it mildly, in doubt.

I would far rather see a diminution in the colossal quota of simple fillings, and more attention given to crown and bridge work, and the modern advances in prosthetics (there are other ways of rendering a person edentulous, than by the fitting of the "gum stripper" as decreed by the puerile denture fees in the Health Service).

As one dentist who is horrified at the apathy shown by the profession to the dilution by these New Cross girls, I wonder how long it will be before their administrations to chilldren are upgraded to include adult patients as well.

If that occurs, then how will we fill the already empty places in some dental schools?

After all, the sixth former will not understand the difference, the public already treats these girls as dental surgeons. Five years to be a dentist or two years to be a "dentist"?

The answer is to show the difference in the skills obtained by each graduate. *If* the dental surgeon has a good technical skill in advanced techniques in all aspects of his profession, and *if* the profession takes the trouble and effort to educate the public in better dentistry than they can expect at present on the National Health, then we have a chance to survive as a profession. The alternative?

Overseers to dental auxiliaries in State clinics . . . and I kid you not.

Yours, etc.,

L. B. LUX.

Strathyre, Warwick Road,
Hale, Cheshire.

Footnote:

I should perhaps explain that I am the honorary Secretary of the General Dental Practitioners' Association, but felt I should write as an ordinary G.P.

However, so that you may understand my feelings, I can tell you that my Association is resolutely against these dental auxiliaries as we feel that nothing less than a fully qualified dental surgeon should attend to children's teeth, the same standard as laid down for adult patients.

L. B. LUX.

Brighton Stroll

SIR,—Much discussion is taking place at present as to the venue of the next "Brighton Stroll", but I feel that an equally important question should also be asked, concerning the functions and purpose of the enterprise. Is it to continue to provide little more than a chance for the men to show their virility and the girls their, well, stamina, or could it be given an over-riding purpose so that it actually achieves something lasting?

On a recent walk from Reading to Oxford (a mere 25 miles) over £3,000 was raised for Oxfam by means of each walker obtaining as many "sponsors" as possible, each of whom agreed to give threepence for each mile that their walker completed. Also local firms sponsored many walkers with large amounts. If such a system could be applied to the Stroll, then, with each walker being sponsored to an average total of about 5s. per mile, between £10,000 and £20,000 could be earned for Oxfam, UNESCO, or another charity. Naturally we would still need the support of the Guinness and Ovaltine Companies, and I am sure they, and perhaps other firms, would be more than willing to back the project.

As the hospitals take little or no part in the money-raising activities of the University of London Rag Week, it seems to me that the Stroll could quite successfully be adapted for this purpose without losing any of its undoubted attractions.

Yours, etc.,

P. G. BUDDEN.

26, Aberdeen Park,
Highbury, N.5.

'The Thatchings", Bognor Regis, Sussex

SIR,—Last August you kindly published a letter from me saying that " The Thatchings " was to close temporarily following the resignation of Mr. and Mrs. Lewis. I am now writing to let you know that Mr. and Mrs. Luckett have been appointed, and that " The Thatchings " was opened again for guests on the 21st November.

Your readers may be interested to know that we have taken the opportunity of replacing the old central heating, redecorating the public rooms and replacing some of the furniture and furnishings. We have also been able to make a small utility room on the ground floor.

Staff or students who would like to stay at "The Thatchings" will be made very welcome by Mr. and Mrs. Luckett, and bookings can be made at the Counting House.

Yours, etc.,

P. LE FLEMING,
Assistant Clerk to the Governors.

Counting House,
Guy's Hospital, London, S.E.1.

GENERAL PRACTICE IN CANADA

by
J. A. Bullard M.D.

This vast continent lends itself to the practice of medicine as envisaged by the medical student of yesteryear. Small hamlets with their own hospitals, where doctors can look after their patients in all branches of the ancient art, to large cities and universities, where standards are equal to any in the world. Alas and alack, Socialism has tainted even the so-called Liberal Party now in power, and a Health Plan became their main platform during the 1965 Election. The planners toured the breadth of the land (approx. 3·500 to 4,000 miles) and informed their political masters that Canada needed a plan.

There is no doubt that the face of medicine will shortly change in Canada and the General Practitioner will be forced into quantity instead of quality medicine in city and in hamlet. In my opinion the North American continent has more neurotics and hypochondriacs to the square mile than anywhere in the world.

Four years ago, Saskatchewan, in the face of tremendous opposition from the medical profession, introduced a Compulsory Medical Plan. In this short time doctors' incomes have risen sharply, together with patient utilization. The doctors are not happy but the public still believes it is getting something for nothing, and so the Health Scheme will continue.

Enough of this meandering: Canada is a magnificent country in which to live, apart from any problems of practising medicine.

In 1955, my wife, son and I left England to reach the Prairies to join a Hungarian doctor in a town of 400 people. The surrounding farming area provided the bulk of his practice and an income of approximately $25,000 (£8,300). We had our own fully equipped hospital and performed most types of surgery; sometimes being snowed in and cut off from civilization for a week at a time. Open ether anaesthetics and spinals were the order of the day and new experiences gave little time for vegetation.

After a year of this we moved to a bigger centre, to a town of 3,000 people and a group of four doctors, a dentist and an optometrist. There is no doubt that a group of this size leads to ideal working conditions. Holidays can be arranged and taken; medical problems can be discussed and more suitable offices can be erected.

With the promise of the Health Scheme in Saskatchewan, my wife, three children and myself moved further west to Alberta. This province boasts the Rockies, untold wealth in oil, natural gas and other minerals. The highways are a joy to behold, particularly as they wind their way through the mountains into B.C. and down into the United States. We live in the foothills in a very wealthy farming area, populated to the extent of keeping six doctors busy and a 40-bed hospital at 90 per cent occupancy.

In the city practice, doctors have less access to hospital beds and unless specialized are restricted to minor surgery plus appendices and T's. and A's. At the moment, the hospital bed situation is very bad and many new large hospitals are required.

In contrast, the rural areas with their own hospitals put very little restriction on the doctor and do not experience the same bed shortage.

A typical day in my practice starts at 8.0 a.m. with operating, ranging from T's. and A's. to gall bladders, hernias, etc. Usually two or three operations are done each day from Monday to Friday. Following this, I see a few patients at the office before lunch. At 2.0 p.m. I start the afternoon office hours, mainly by appointment. We have our patients fairly well trained to consider 5.30 p.m. the end of regular office hours. Hospital rounds are done first thing in the morning and at night. Added to the day are maternity cases (50 a year), house calls, occasional country calls and emergencies.

In addition to practising medicine to the extent of my capabilities as a Guy's man, I lead a very full social life. In the summer I play soccer, make frequent visits to the lakes nearby with my family, play an active part in organization of Field and Track in the Province, attending meets, lecturing and travelling to other provinces. My son, now 16 years of age, has shown great promise on a National Level, running half-mile, mile and cross-country. In the winter I ski and head the local Hockey Executive, keeping a Senior team going. In the course of the year my wife and I take trips to the United States for Post-graduate studies. We sailed to Bermuda and the Bahamas on one such trip and drove to Los Angeles on another.

I'm glad I emigrated for it has allowed me to practise total medicine, justify my Guy's training and enjoy life to its fullest.

NURSING SECTION

Post-Graduate Education for Nurses

It has always been the custom for nurses when they have completed their general training to consider it necessary to attain further qualifications. Certainly most senior posts demand the experience that is gained when one qualifies in a second subject.

Midwifery has been the easiest subject for post-graduate nurses to obtain in terms of availability, but many more hospitals are now awakening to the fact that there are other subjects which can be offered to the nursing profession.

Types of courses that are now available:

The nursing of Accidents and Casualties; the Nursing of Burns; the nursing of conditions of the Ear, Nose and Throat; Neurological nursing; Operating Theatre nursing; Ophthalmic nursing; Orthopaedic nursing; Paediatric nursing; Thoracic nursing; Urological nursing; training for the Mental Register; and so on.

A nurse who is interested in separate qualifications would find that taking a course in a specialised subject, she would cover the whole aspect of the subject. If she just worked on the ward involved, then all she would see would be the certain more practical branches.

Why should nurses take extra courses?

There are two primary aims in advanced nursing training. The first is that a course would stimulate better nursing care through practice, and the second—to impart knowledge.

Methods of running courses:

To run a course, the planners must relate the teaching facilities with the housing, recreation, public relations, finance and communications. Recruitment and the availability of tutorial staff are also large factors which have to be taken into consideration.

It is relatively easy to get a course off the ground if the hospital concerned is specialised itself—e.g. orthopaedic or paediatric. The problems which are apparent in this case do not apply to those encountered when one is considering operating courses within the confines of a general hospital.

It is becoming more apparent that In Service Education is the method that must be used by General Hospitals. There is relatively small expense in time and money, thus lessening demands on more expensive types of post-basic education that are difficult to organise. Continuous in-service courses can be used as a preparation for specialised work. They should be planned over a period of months in each year and planned ahead for a number of years. There is always the problem of a large turnover of staff, and this would have to be overcome by the running of orientation courses every year or half-year. However, permanent staff should be able to proceed to a higher level of education.

Classes run in these courses must be of the calibre to attract the students by their intrinsic worth. They must be kept alive and inspired and the nurse must be physically free to attend them. This means that it is not enough to let a nurse go to a class for the requisite number of minutes. She must be genuinely relieved of physical work and all responsibilities by passing them over to another, and have enough time not only to attend the class, but to arrive in a calm and relaxed frame of mind, to consider, study and discuss the learning imparted.

Seminar studies are a very effective way to teach nurses, and individual study is imperative. However, in all these, the nurse needs help in planning practical work and integrating it with all the theory necessary.

At the end of any course there must be official recognition in the award of certificates or diplomas, and prior to the attainment of these certificates there must, of necessity, be examinations. It is often advisable for the course planners to set occasional tests throughout the period to enable the nurses to evaluate the standards of their own work.

The people necessary ot run courses:

There must be a committee of planners who have the aim and object of the particular course in mind, but who can also see the course merely as one part of nursing education, both student and post-graduate. This planning committee must be made up of tutors and administrators who can work in close liaison with the physicians and surgeons and others who combine to make up the teaching staff of a teaching hospital.

It may well be necessary to run refresher courses in conjunction with the post-basic education courses. These refresher courses can be made to last a few days or a few weeks and have a number of aims:

(a) Complimenting scientific aspects of the basic nursing programme.

(b) Keeping the nurse up to date in her work.

(c) Stimulating better nursing practice.

The value of post-graduate education to the basic trained nurse:

To learn a subject one must learn it as a whole and then break it up into component parts. This means that once a nurse has completed her basic training, then she should be encouraged to seek knowledge in greater detail and learn better nursing skills by attending specialised courses. Only in this way can nurses be stimulated to remain in practice, and by means of in-service education be encouraged to remain at their parent hospital. Nurses should be advised not to chase too many qualifications, and to demonstrate the value of any course she has attended a nurse should be urged to spend a certain amount practising in her speciality.

The value of post-registration courses to the general hospital:

A nurse who has finished her general training always feels that she owes her training hospital a great deal in the way of loyalty and affection. If, to improve her education she has to move from hospital to hospital, then her parent hospital has lost a potentially good and loyal nurse. If, however, the parent hospital can offer the nurse further education within its four walls, then it will find it easier to retain its staff.

STAFF CHANGES AND APPOINTMENTS

DEPARTURES

Sister E. Wood, from Job Ward.
S/N D. Hall, from Nurses Sick Room.
S/N G. Sawyer, from Nuffield C Floor.
S/N N. Wade, from Cornelius Ward.

APPOINTMENTS

S/N U. R. Goldsbury, S.R.N. (Johannesburg Hospital), to Renal Dialysis Unit.
S/N M. J. Lenne, S.R.N. (Mooroopna and District Base Hospital, Victoria), to Main Theatres.

REVIEW

OBSTETRICS,
by Ten Teachers. 11th Ed. Edward Arnold. 744 pp. *Price* 65*s*.

When reviewing a new edition of a famous and successful textbook, one is inevitably chary of being too critical. There are, however, features of this book that, in the context of the current debate on Medical Education, do require a critical reappraisal.

Obstetrics is perhaps the most satisfying practical fields in medicine. Its teaching is still, however, dominated by opinion rather than fact, and the final examinations in the subject are still too often concerned with whether the candidate can assess the age and attitudes of his examiners correctly.

Such an influential textbook as this could play a liberalising rôle if only it reproduced more statistics in support of its statements especially when discussing management; ideally these could be similar to those it gives on the 1956 Perinatal Mortality study at the end of the book. In many instances, it must be admitted, reliable figures do not exist either way, but it would be a beginning and set a definite precedent for scientific honesty in this subject if what evidence had been obtained was summarised and published in the text-books at this level.

Leaving aside this general criticism and turning to the book itself, the new revision has made a considerable improvement by cutting down on the former lengthy treatment of mechanical complications of labour and devoting the space saved to the physiology of pregnancy and labour. There is still, however, perhaps an unnecessary lack of emphasis in its dealings with the practical issues, and what the operator should do (or more important, what he should not do), tends to get bogged down in descriptive details.

Also at a time when there are more diabetic mothers than ever, there is one omission that is hard to account for, and this is the management of shoulder dystocia. This practical emergency that every accoucheur should have been taught something about, is not mentioned at all.

Apart from these points, the book is still easily the best buy on the market. Quaintly but well illustrated, it continues its tradition of high quality.

M.F.D.

SPORT

RUGBY FOOTBALL

After a fortnight without a hospital fixture, Guy's re-commence against Cheltenham this Saturday. The latter are having quite a fair season and will take some beating. On the following Wednesday, Guy's play the Buckinghamshire County side, which may include Ashby, one of the three scrum-halves who played for England in last season's internationals.

The following Saturday, Guy's play Streatham and Croydon, one of Guy's bogey sides. Whether Guy's play badly or Streatham play well in this fixture, it is difficult to tell, but Guy's really should defeat Streatham.

The United Hospital tour to Scotland was most successful with victories over Edinburgh and St. Andrew's Universities. In the Scottish trial in Glasgow, Thorburn, from all accounts, played well although on the losing side.

HOCKEY

The first Hospital Cup victory of this season goes to the Hockey Club, who easily defeated Westminster Hospital 5—0. Westminster were woefully weak and it is difficult to judge Guy's chances of winning the Cup from this result. As is usual when two sides are very unevenly matched, the stronger of the two did not play flat out, and from the amount of attacking Guy's did, a much larger victory should have resulted.

Guy's will have had another Cup match by the time of publication against the London Hospital. This match will have shown how good Guy's really are; we hope that we shall be able to record a victory in this match in the next issue.

In Club matches, Guy's have not fared very well in the last fortnight, losing 3—0 to both Gravesend and Surbiton 2nd XI.

SOCCER

Guy's have shown quite a marked improvement in their last few games, defeating R.M.A., Sandhurst, 6—0; Sir John Cass College 9—3; and losing 2—1 to Eton Manor Strollers. Of more importance was their 3—1 victory over Charing Cross Hospital last Saturday in a United Hospitals League match, as they play Charing Cross again this Saturday in their first Hospital's Cup match. Because of this victory, Guy's must be favourites to repeat their win.

SQUASH

The Squash Club's Sussex tour was again a successful event, although they won only one of the three matches. They defeated Brighton 3—2, but lost to Middleton 3—2, and to Chichester 4—1.

We must congratulate J. Newman on winning the Kent Squash Championships; this is a truly fine effort by Newman against some considerable opposition.

DIARY

RUGBY FOOTBALL.

November	Sat., 26th—Cheltenham. Home.
	Wed., 30th—Buckinghamshire County R.F.C. Home.
December	Sat., 3rd—Streatham/Croydon. Home.
	Sat., 10th—Old Cranleighans. Home.

SOCCER.

Novembes	Sat., 26th—Charing Cross Hospital (U.H. Cup). Home.
	Wed., 30th—Royal Dental Hospital (U.H. League). Home.
December	Sat., 3rd—Queen Mary College (U.L. Cup). Away.
	Wed., 7th—King's College Hospital (U.H. League). Home.

HOCKEY.

November	Sat., 26th—Merton. Home.
December	Wed., 3rd—Bexleyheath. Away.

LADIES' HOCKEY.

November	Sat., 26th—London School of Economics. Away.
December	Sat., 3rd—St. Bartholomew's Hospital. Home.

SQUASH.

November Tues., 29th—Coolhurst (Cumberland Cup). Away.
December Thurs., 1st—Sundridge Park. Home.
Tues., 6th—St. Thomas's Hospital 1st V. Away.
(Cumberland Cup) 2nd V. Home.
Thurs., 8th—Eastman Dental Hospital 2nd V. Home.

ROWING.

December Sat., 3rd—University of London Winter VIII's.

GOLF.

U.H. Cup Final v. St. Bartholomew's Hospital at Royal Berkshire Golf Club, November 30th.

HOCKEY

GUY'S 1st XI v. SURBITON 2nd XI

At H.O.P. Saturday, 19th November

Result: lost 0—3

Surbiton 2nd XI proved to be the toughest and most talented opposition that Guy's have been pitted against so far this season, having at least one current county player in their ranks. Their class and experience proved too much for the home side and the result was a fair one, although the Hospital fought valiantly.

The first half comprised some good hockey, and there were a few good movements by Guy's down both wings, culminating in menacing centres into the circle which the inside trio just failed to convert into goals. However, by the time the closing stages of the game had been reached the play had degenerated into a disjointed defensive scramble from the Guy's point of view and a failure by the Surbiton forwards to apply themselves and concentrate on constructive attack, an almost inevitable approach from a line which had three goals to its credit and which had throughout the game had the measure of the defence.

By the time this report is published the result of the quarter-final of the Hospitals' Cup against the London Hospital will be known. It is interesting to note that while Guy's were sustaining this defeat, our Cup rivals were beating Southend 4—0.

J. K. CRAFTS

Team: N. White; M. Vellacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, H. McMichen, N. Dodd, M. Appleby, S. Cripps.

GUY'S v. GRAVESEND

Away Saturday, 12th November

Result: lost 3—1

This was the Hospital's poorest performance for some weeks. Gravesend always provide stern opposition, but it is in fact the first time they have beaten Guy's for four years. Though the pitch was unpredictable, the basic difference between the two sides was in ball control—that of Guy's was inadequate.

Not for a long time has the defence come under such pressure, and on this occasion they tended to panic unnecessarily, committing themselves to the tackle too early, and making wild clearances. J. Crafts had another sound game, and White played a courageous game in goal. There was very little penetration in the forward line; too much of the passing, especially by the insides, was inaccurate and slow. Apart from the goal, the Gravesend goalkeeper only had one shot to save in the whole game—a sad reflection on the Guy's attack.

Gravesend were in command for the first half, and led 2—0 at the interval. Both goals were scored by their right-wing; the first was a fine angled shot, and the second came after a left-wing attack had opened up the Guy's defence.

Gravesend went further ahead from a short corner early on in the second half. However, Guy's now tightened up their play and managed to pull back one goal when Brooks converted a left-wing centre. Though Guy's continued to press, they could not create many more chances, and the final whistle sounded leaving Gravesend deserved 3—1 winners.

M. I. APPLEBY

Team: N. White; M. Vellacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, H. McMichen, D. Steer, M. Appleby, S. Cripps.

LADIES' HOCKEY

The two practices and trials held at H.O.P. at the beginning of the season were well attended and of higher standard than previous seasons. It was obvious that there was a promising influx of hockey players, which added to last year's intake have the makings of a group of enthusiastic hockey players who could well meet with success.

The team did not have a successful start to the season, our first two matches being against our strongest opponents. However, now the players are fitter and becoming more used to playing together we are meeting with more success.

So far we have played five out of six matches, which must surely be a record, at least for the past three seasons. Twenty people have played in these five matches. The Club's greatest difficulty is organising the best eleven players to play at one time. However, we hope to achieve this for the 1st Round of the Hospitals' Cup v. St. Thomas's Hospital on November 23rd at Cobham.

We are grateful for those members of the men's club who have umpired for several of our matches and given constructive criticism of our play.

Four members of the team attended the University Trials at Motspur Park. Rosalind Thorburn, a Fresher, was selected for the 2nd University Team, and Ann Collins, Mary Fortnam and Sue White for the Reserve Team.

Ann Collins is Secretary of U.H. for season 66-67. Irene Cormac, Rosalind Thorburn (both Freshers), and Sue White have also played for the U.H. team this term.

Results:

Sat., Oct. 15th. v. King's College, at Mitcham. Lost 0—5.
Wed., Oct. 26th. v. St. Mary's Hospital, at Teddington. Lost 0—8.
Wed., Nov. 2nd. v. University College, at H.O.P. Cancelled.
Wed., Nov. 9th. v. Royal Veterinary College, at Barnet. Won 2—1.
Wed., Nov. 16th. v. Goldsmith's College, at Cobham. Drew 0—0.
Sat., Nov. 19th. v. Charing Cross Hospital, at Cobham. Drew 1—1.

MARY FORTNAM

SOCCER

GUY'S v. R.M.A. SANDHURST 2nd XI

At Sandhurst 9th November, 1966

Result: won 6—0

Straight from the kick-off Guy's made all the early running, with Poole particularly

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prominent. For once, it was Guy's who opened the scoring through a long-range shot by McClure. The Hospital team was playing neat football, and it was no surprise when they increased their lead through Jacobs. With the Guy's defence looking more secure than of late, little was seen of the home team's attack.

In the second half Guy's continued to play intelligent, crisp football, keeping the play in their opponents' half for long periods. Lindridge, from a free kick, and Poole, put Guy's further ahead. With the half-backs frequently up in support, it was one-way traffic, and goals by McClure and Jacobs emphasised Guy's superiority. The former, in his debut for the Hospital, had a fine game, fitting well into an efficient attack. A feature of the game was the Guy's passing, which was much better than on previous occasions, very few balls not finding their men.

The home team were restricted to a couple of good efforts by their centre-forward, but the final score of 6—0 was a fair reflection of the game.

This was Guy's best display of the season so far, and it showed that they are capable of very good football when they play as a team, not as individuals.

Team: M. Carter; R. Davey, S. Watt-Smith; R. Lovell, I. Nash (Capt.), D. Lindridge; T. Dutta, S. Poole, D. Jacobs, J. Allen, I. McClure.

R. LOVELL

GUY'S v. EATON MANOR STROLLERS

At Leyton 11th November, 1966

Result: lost 2—1

On a cold evening, Guy's kicked off against the older strollers team. The match was played on an almost grassless pitch and under floodlights, only half of which were working. The conditions, therefore, did not favour good football, and constructive play was not forthcoming.

The match was evenly balanced, and Guy's went close to scoring several times in the firt half. However, the Strollers were first to strike and went ahead through their centre-forward who scored with a fine running shot. The opponents' defence seemed dominant, rather by physical force than defensive skill, but the Hospital drew level with a goal by Poole in the second half. Guy's came more into the game, but the forwards missed the chances that were created. The Strollers, however, scored the winning goal through their opportunist centre-forward who was given too much room to move by the Guy's centre-half.

Team: M. Carter; R. Davey, S. Watt-Smith; R. Lovell, I. Nash, D. Lindridge; T. Dutta, S. Poole, D. Jacob, I. McClure, R. Leeburn.

I. T. NASH

GUY'S v. CHARING CROSS

At H.O.P. 19th November, 1966

Result: won 3—1

Guy's faced Charing Cross for their league match with a full strength side, hoping to gain some pointers for their second round Cup game on the 26th against the same side.

The game started with Guy's fielding ten men, due to a late arrival. The game started at a good pace, and Guy's did a lot of the attacking in the opening minutes. However, the forwards failed to impress and were cut out by the hard tackling Charing Cross defence. The visitors linked up well between attack and defence and would have opened the scoring but for some good saves by Carter and strong tackling from Davey an Lovell.

Play was even at this stage and the game needed a goal to liven it up. A cross from the right beat the Charing Cross defence and found Lindridge who only had to tap it in to put Guy's one up.

Guy's team, including four freshers—Carter, Smith, Evans and McClure, were not finding the form that had given them some easy wins in recent games. The forward line did not seem able to link up at all, although the defence was playing one of its best games this season. Evans, at left-back, was having a much better time than he had had at centre-half.

Guy's went further ahead in the first half from a well taken goal by McClure who, at outside-left, has been playing well since recovering from a broken toe.

Half time: Guy's 2; Charing Cross 0.

Charing Cross kicked off and soon started attacking, but were well held. The visitors' inside-left was causing a lot of bother, both with his robust football and his mouth. A penalty was given against Guy's after this forward was kicked whilst holding the ball between his legs whilst on the ground.

Guy's were now beginning to feel the pressure but soon broke loose. Poole took the ball out of the defence and pushed a through ball to Dutta, who ran forward holding the ball back and timing his shot which left the opposition goalkeeper standing. Guy's now contained the game and ended with their sixth win of the season.

It is hoped that Guy's can keep on winning and possibly keep the Cup and win the league.

The Soccer Club invites everyone at Guy's to the second round of the Hospitals' Cup at H.O.P. on Saturday, November 26th, kick-off 2.0 p.m., against Charing Cross.

There will be a game—Past v. Present—on Sunday, December 11th, at H.O.P., kick-off 2.0 p.m. The losers to pay for a barrel of beer (72 pints). The past team is to be captained by Mr. A. Stewart. The club welcomes anyone to come and enjoy both the game and the beer.

Team: M. Carter; R. Davey, P. Evans; R. Lovell, I. Nash (Capt.), S. Watt-Smith; D. Jacobs, S. Poole, T. Dutta, D. Lindridge, I. McClure.

D. LINDRIDGE

SQUASH CLUB

The squash team has won one match and lost two in the Cumberland Cup. We lost 4—1 to Eton Manor on very slow courts, and beat I.C.I. at home 5—0, which was a very heartening victory. The Sussex tour was very successful socially. We played Brighton on the Friday night and won 3—2; on Saturday, after 18 holes of golf, we lost 3—2 to Middleton, and on the Sunday lost 4—1 to a very strong Chichester team, J. Newman having a good win 3—1 against M. Scott. Since the last report, J. Newman has won the Kent Squash Championship—the is a remarkable effort considering the opposition. The main concern at the moment is staying in Division III of the Cumberland Cup.

J. R. WEBB, Secretary

BOAT CLUB

The United Hospitals' Regatta, 1966

This year the Boat Club had its highest intake of freshers it has ever known. This produced a tremendous strain on the equipment, facilities and coaches, such that despite keenness on the part of the new members, we were unable to give them the intensive training needed to prepare them for this regatta in six weeks. Nevertheless, they produced the best novice four Guy's has had in recent years and three more besides.

We decided early on in the term to form a Junior VIII, as our First VIII, to go for the Eights' trophy at the regatta. This crew was made up from four of last year's first crew and no fewer than four freshers with two or more year's rowing experience.

This left some of Guy's best oarsmen without a crew, and so we began a Senior Four, making use of our third boat—an excellent, but little-used, light four.

The Second VIII were also entered in the Junior division, and because of a chronic lack of coaching produced an unwilling crew with a rare mixture of personalities.

Junior VIII's division

Owing to a record entry, the races had to be run with three crews abreast. In this division, this meant that the first race was in fact the semi-final.

The First crew met St. Thomas's and the London in their race. There was a high wind, which, incidentally, continued all day, and it was bitterly cold on the water. A crew's first race of the day is generally the worst, and this was proved correct yet again. Our start was ruined by an inarticulate umpire and we tried again. This time all was well and a rather rushed start gained us nothing on the other crews. Soon, however, London began to flag and were left behind; slowly Thomas's followed, and surprisingly we finished a length-and-a-half ahead.

The final was late in the afternoon, and we were tipped as favourites by most other clubs. The water was very choppy, but with crisp beginnings and a longer stroke than normal, we went steadily away from our opposition—Royal Vets and Middlesex. It was as we were three-quarters of a length up on the Vets and going away that our cox met his match. He was edging the Vets over so that we might gain further advantage from the swiftly flowing tide. Alas, he pushed too far and we clashed blades. This spelled disqualification for our crew and prevention of certain victory.

Our thanks must go to Battersea College of Advanced Technology for the loan of their clinker boat, which was invaluable.

Crew:

Box M. Fortune.
2 P. Moulder.
3 C. West.
4 J. Miller.
5 M. Mace (Capt.).
6 P. Hunt.
7 A. Batch.
Stroke R. Mandeville.
Cox T. Kirk.

The Second VIII raced the Royal Vets and Westminster in their race. They had a superb start taking them up a canvas, but somewhere down the course the middle of the boat began to rush and the power slackened off. Guy's arrived at the finish third.

Crew:

Bow M. Gross.
2 R. Knowles.
3 R. Salt.
4 M. Faulkner.
5 I. Wilkinson.
6 J. Skuse.
7 J. Swain.
Stroke J. Osborne.
Cox G. M. Thomas.

Junior IV's division

As is becoming standard practice, we entered a scratch crew in this division, consisting of four members of the First VIII. Here again only two races would have to be rowed. In the first we walked over St. Thomas's and St. George's "A", which was very pleasing. This meant two finals for us, so plenty of rest and relaxation was necessary. The final of the Junior IV's came only ten minutes after the horrible disqualification of the VIII so we were even more determined to win. The opposition was King's College Hospital and University College Hospital. We had a superb start, leaving U.C.H. well behind, but our true opposition was now unveiled. K.C.H. were, if anything, slightly in the lead. Miller was stroking our boat and not a flicker of panic crossed his face as he lowered the rating and lengthened out into a magnificent stride. King's could not reply to this brilliance and we rowed through them to win by a canvas.

Bow A. Batch.
2 P. Moulder.
3 M. Mace.
Stroke J. Miller.
Cox T. Kirk.

Our thanks are due to Birkbeck College and the London School of Economics and Political Sciences for the loan of their boats, enabling us to win this trophy.

Senior Four

Having used borrowed boats so far this season, the senior four was somewhat apprehensive when they found that their own boat was at last ready after being hurriedly overhauled the previous night by the boatman.

Their heat was against Bart's "A" crew, which was thought to be formidable opposition. Both crews made a fairly settled start in the stormy conditions, and the Bart's crew gradually took the lead by a few feet. At the finish the position was much the same after a very close race, and Bart's finished about half-a-length ahead.

Crew:

Bow (steers) G. W. H. Stygall.
2 M. A. Preece
3 R. J. Morgan
Stroke I. Grimble.

Senior Sculls

P. Crooder, who won the Junior Sculls last year, entered this division. He had to row in an unusual boat and unfortunately was narrowly beaten.

Junior Sculls

Four scullers were entered in this division. None of them won their races. Perhaps the most noble performance of the day was that of Bishop, an entirely self-taugh sculler, who sailed into the lead at the start in a rum-tum against the opposition in a gig!

Scullers: R. Forrect, G. Taylor, M. Bishop, N. Pinckney.

Novice Fours

The "B", "C", and "D" Crews, after valiant efforts, were beaten in their first races. The "A" crew won two good races, losing in the final to the Royal Dental Hospital. All the novices are to be congratulated on their efforts this term

My thanks are long overdue to Jonathan Williams who has coached Guy's novices for the last two years. He has been most reliable and produced a very high standard this year. Also thanks to A. Taylor and T. Haywood.

Crews:

"A"	"C"
Bow P. Robinson.	Bow K. Malone.
2 A. Fenn.	2 G. Brain.
3 C. Wilde.	3 G. Barker.
Stroke B. Parker.	Stroke A. Ross.
Cox A. Taylor.	Cox M. Bishop.
"B"	**"D"**
Bow D. Downing.	Bow B. Wooster.
2 J. Klossok.	2
3 A. Lalani.	3 P. Sharples
Stroke T. Gould.	Stroke C. Clare.
Cox R. Stanley.	Cox N. Davis.

M. C. MACE, Captain of Boats

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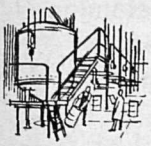
This is the idea that started the plan of the Hormone house that Organon built.

This is the researcher who had the ideas that started the plan of the house that Organon built.

This is the rat that was there at the start, as well as the cows, the sows and rabbits that enabled the researchers to probe the secrets of the hormones which built the house of Organon.



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HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Ear, Nose and Throat Surgery,** with appointment from 1st February until 30th September, 1967, in the first instance. The successful applicant may be required to take part in the Exchange Scheme at Lewisham Hospital at some stage in his appointment. Forms of application are obtainable from the Superintendent, Guy's Hospital, S.E.1, and should be returned to him not later than **6th December, 1966.**

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Senior House Officer (General Medicine and Paediatrics) from 1st January. Six months' appointment (renewable). Write with testimonials/references to Group Secretary, G. & D. H.M.C., at hospital.

GREENWICH DISTRICT HOSPITAL
Miller General Wing, Greenwich High Road, S.E.10. (189 beds)
Recognised for F.R.C.S. Examination

House Surgeon vacant 31st December. Six months' appointment. National salary and conditions. Write with testimonials/references to Group Secretary, G. & D. H.M.C., Greenwich District Hospital, St. Alfege's Wing, Vanbrugh Hill, S.E.10.

HOUSE APPOINTMENTS

GUY'S HOSPITAL

December 1st, 1966

House Surgeons

To:

Mr. Eckhoff — Mrs. I. M. J. Mathias, 6 *months*

Professor Atkins — Mr. M. H. Jourdan, 3 *months*

Mr. Wass — Mr. H. G. Sturzaker, 6 *months*

Mr. Blackburn — Mr. T. H. Guerrier, 3 *months*

Mr. Lawrie — Mr. C. C. Penney, 3 *months*

Mr. Glover — Mr. P. G. Ransley, 6 *months*

Mr. Brain — Mr. R. O. Robinson, 3 *months*

Mr. Beard — Mr. A. B. Bevan Jones, 6 *months*

House Physicians

To:

Dr. Mann, Dr. Scott and Dr. Bishop — Miss L. M. Rikard-Bell, 6 *months*; Mr. J. D. Powell-Jackson, 6 *months*

Dr. Hardwick, Prof. Trounce and Dr. Deuchar — Mr. C. A. Soutar, 6 *months*; Mr. R. B. Stott, 3 *months*

Dr. Baker, Dr. Houston and Dr. Grimble — Mr. D. J. Hendrick, 3 *months*; Mr. M. F. D'Souza, 6 *months*

Dr. Kauntze and Dr. Joiner — Mr. P. C. Pietroni, 3 *months*; Mr. M. E. French, 3 *months*

Prof. Butterfield and Dr. MacLean — Mr. R. A. J. Spurrell, 6 *months*; Mr. J. V. Collins, 6 *months*

Casualty Officers

Mr. R. C. Day, 3 *months*

Mr. J. M. Boulton Jones, 3 *months*

Mr. G. A. Machin, 3 *months*

Mr. J. De Nobrega, 6 *months*

Vacant, 6 *months*

Vacant, 6 *months*

House Surgeon to the Surgical Unit

Mr. D. Tong, 6 *months*

Resident Obstetricians

Mr. S. M. Wood, 3 *months*

Mr. T. N. D. Peet, 6 *months*

Gynaecological House Surgeon

Mr. P. Bowen-Simpkins, 3 *months*

Throat and Ear House Surgeons

Mr. D. B. Mathias, 3 *months*

Mr. R. S. B. Bramwell, 6 *months*

Neurological House Physician

Mr. G. A. Pettitt, 3 *months*

Orthopaedic House Surgeons

Mr. G. Smith, 3 *months*

Mr. J. R. C. Sharp, 6 *months*

Dermatological House Physician

Miss M. K. H. Johnson, 3 *months*

Genito-Urinary House Surgeon

Mr. J. F. Searle, 6 *months*

House Surgeons to the Thoracic Unit

Mr. J. R. W. Keates (S.H.O.), 3 *months*

Mr. D. H. Enderby, 3 *months*

Children's House Physicians

Mr. A. W. J. Medhurst, 3 *months*

Mr. J. M. Brummitt, 6 *months*

House Physicians in Clinical Pathology

Miss C. Surin

Vacant, 6 *months*

House Physician to Dr. Bishop, Dr. Wayte and Mr. McArthur

Mr. L. D. Byer, 3 *months*

House Physician in Child Psychiatry

Miss J. Robinson, 3 *months*

House Physicians in the Department of Psychological Medicine

Mr. S. Bhanji — 1.10.66—31.3.67

Mr. B. H. Anstee — 1.10.66—31.3.67

R.M.O.s in Nuffield House

Mr. J. Macleod — 1. 7.66—31.12.66

Mr. P. B. Ashcroft — 1.12.66—31. 5.67, 3 *months*

Miss H. Kerr — 1. 1.67—30. 6.67

Resident Anaesthetists
Mr. I. A. Sutherland
3 *months*
Mr. D. J. Openshaw
3 *months*
Mr. M. S. Vernon
6 *months*
Mr. P. A. D. Williams
6 *months*

Children's House Physicians at the Evelina Hospital

Mr. J. C. Robertson	1. 8.66—31.1.67
Mr. J. R. T. Gabriel	1.10.66—31.3.67
Mr. R. A. Sturge	1.12.66—31.5.67
Miss J. C. Summerscale	1. 2.67—31.7.67

Casualty Officer at the Evelina Hospital
Mr. B. G. R. Neville
3 *months*

ST. OLAVE'S HOSPITAL
House Physicians to Dr. Mason and Dr. Cox:
Mr. J. S. Gregson
3 *months*
Miss H. Hale
6 *months*
House Surgeon to Mr. O'Flynn:
Mr. J. M. Richards
6 *months*
House Surgeon to Mr. Lewys Lloyd (S.H.O.):
Mr. J. Barnes
6 *months*
House Physician to Dr. Cox (S.H.O.):
Mr. K. Sheth
10 *months*
Gynaecological House Surgeon (S.H.O.):
Mr. B. W. Hackman
3 *months*
Casualty Officer (S.H.O.):
Mr. B. C. Rosenberg
6 *months*

NEW CROSS HOSPITAL
House Physicians in Medicine and Geriatrics (S.H.O.):
Mr. D. J. Simler
3 *months*
Mr. C. D. Eraut
3 *months*
(S.H.O.):
Mr. D. J. Ewing
6 *months*
Mr. D. F. H. Wardle
6 *months*
Orthopaedic House Surgeons
S.H.O.: Readvertised
6 *months*
Mr. J. E. Davies
6 *months*
S.H.O. to the Rehabilitation Unit:
Mr. M. L. Ingpen
6 *months*

JOYCE GREEN HOSPITAL
House Physicians:
2 vacancies readvertised

LEWISHAM HOSPITAL
House Physician to Dr. Roberts:
Mr. A. H. O'Donnell
6 *months*

ORPINGTON HOSPITAL
House Surgeon with Orthopaedics:
Readvertised

PEMBURY HOSPITAL
House Surgeon:
Mr. H. J. N. Bethell
6 *months*

ST. JOHN'S HOSPITAL, LEWISHAM
House Surgeon with Gynaecology:
Readvertised
House Surgeon with Gynaecology and Orthopaedics:
Readvertised

ST. NICHOLAS HOSPITAL
House Physician to Dr. Scott:
Mr. A. E. Raynes
6 *months*

MILLER GENERAL HOSPITAL
House Physician to Dr. Lessof:
Mr. M. E. Pembrey
R. J. CANN,
Acting Superintendent

PERSONAL

ASSISTANT/ASSOCIATE. Excellent opportunity for married B.D.S. in good class practice with self-contained unfurnished flat above in mid-Sussex market town. Box No. 66/26/11.

FURNISHED HOUSE TO LET. Modern 4-bedroomed house in Dulwich to let for one year from January 1st. All modern amenities. 10 minutes London Bridge. Contact Dr. Cotton, Gipsy Hill 7585.

CHANGES OF ADDRESS

Mr. Anthony A. Bailey, 6, Neville Close, Esher, Surrey (Residence); 57, Harley Street, London, W.1. (Practice).

Dr. Peter F. Stebbing, 56, Belmont Hill, Lewisham, London, S.E.13. (Residence); 76, Herbert Road, Woolwich, London, S.E.18. (Practice).

BIRTHS

GREENWOOD.—On October 13th, 1966, at Trail, British Columbia, to Joan (née Keizer) and Noel Greenwood, a daughter, Penelope Ann, a sister for Gillian and Joanna.

OWEN.—On 29th October, 1966, to Marion (née Oates) and Roger Owen, a son, a brother for Lance.

MARRIAGE

CRADDOCK—STEVENS.—On 24th September, 1966, at Ponteland Parish Church, Northumberland, Nigel Christopher Craddock, A.C.I.I., and Penelope Jane Stevens, S.R.N., S.C.M. (Part 1).

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

Birth, Marriage, Death and Change of Address notices are without charge to subscribers. For Personal notices the charge is £1 1s. 0d. for 15 words, additional five words 10s. 6d. minimum 15 words. Non-subscribers will pay £1 1s. 0d. for all notices other than Personal which will be charged at the above rate.

GUY'S HOSPITAL GAZETTE

EDITORS M. F. D'SOUZA and D. S. ROBINS
SPORTS CORRESPONDENT G. E. RATCLIFFE
NURSING CORRESPONDENT E. A. MALPAS

FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2045

PASSIM

Seat First

That students should see physical signs at the bedside was a cause championed by many of the great names of the past, not least among them Hodgkin in our own hospital, and Osler at Oxford. Today we reap the rewards of their thinking and few would dispute the enormous value to students of actually seeing patients about whom they are being taught. It is perhaps for this very reason, however, that it is such a pity that the teaching round has so often to be reduced to an uncomfortable ritual. A whole round trooping out to stand for two hours talking around the bed of a patient who need not be there at all is not paying the cause of bedside education anything more than lip-service. It is shameful that most of our teaching hospitals have so few facilities for doing adequate sedentary teaching close to the ward. One hopes, however, that in the projected new Tower Block there will be ample seating on each floor for the teaching round with near-by points set up with viewing boxes for X-rays, etc., and a blackboard. The patient may then be left alone when not needed and the student may more easily listen to the topic of the round rather than devoting his attention to trying to make his legs more comfortable.

Footnote :

There is, of course, no end to the ways in which fresh thinking can improve teaching. Recently we heard that a consultant, finally frustrated by the lack of light on a patient, suggested that by turning the bed through 180 degrees the light from the windows would fall directly on the patient rather than diffuse from behind his head. And with no more ado the scheme was instituted. The effect is radical and the demonstrating is apparently much improved, even if in the process the patients are turned back to front and the ward inside out.

Hearts in other places ?

While Passim is only too used to the inventive prostitution of its own contents by the popular press and receives the press cuttings in the humorous spirit that most of them deserve, it is, every now and then, that this humour is violently shaken when gross misrepresentations are seen to be dangerous to the public and at great variance with the interests of good medicine.

There recently appeared in the popular press, and to our greater consternation in even more erudite papers such as the *Guardian* and in a journal whose name, *Medical Tribune,* implies a greater degree of information than average, a number of articles concerning available surgery for babies with congenital heart disease. In almost all of these articles the statement was made or overtly implied that the only centre for surgical treatment of the hearts of these babies was the Great Ormond Street Hospital. A widely-appearing advertisement put out by the British Heart Foundation Children's Appeal at about the same time made the same unfortunate implication.

To parents whose children with congenital heart disease are currently under centres equally able both in investigation and treatment, and Guy's is by no means least amongst these, such statements cannot fail to arouse enormous anxieties as to the competence of those in charge of their children's health. The devastating effect that must be produced on learning from the press that their child is not in the "only one centre" for adequate treatment can be nothing but an increase in the tempo of the environment of anxiety which pervades these parents' lives. Already parents of such a child have enquired of a consultant paediatrician at Guy's whether they should be sending their child to Great Ormond Street instead.

The British Heart Foundation, we are pleased to see, have now modified their advertisement. The responsibility for the accuracy of such printed matter is equally that of those who release the material and those who print it. While we have little knowledge of exactly what information was issued, although Great Ormond Street have not publicly refuted the implications, we can comment on the great disservice the press involved has done to the cause of medicine. We have previously suggested that they could do well to get medical correspondents in even half the number they have of defence correspondents. We should have added that these correspondents should also take the elementary precautions of checking their information with a source other than the original. If this is not enough may we humbly offer our services; in fact, for half the money we could probably be tempted to do the job ourselves. For at the moment, sad to relate, in the field of medicine in the lay press, no news is good news.

DR. ROWLAND HENRY (GINGER) FARRELL, D.F.C.

Ginger Farrell died on Saturday, November 26th, and, though it was not unexpected, the world is a sadder place.

Like many of his ex-Service friends, he entered Guy's shortly after the war. He had served with distinction for six years in the R.A.F., leaving with the rank of Squadron Leader. As one would expect, his student career was an outstanding one and, after qualifying M.B.B.S. (Lond.), he was successively Asst. House Surgeon, Out-Patient Officer and House Physician at Guy's. In April, 1953, he was awarded the Treasurer's Medal and Prize for Clinical Medicine. A brilliant career was tragically cut short by a severe and crippling illness, but he practised for a time in Crawley, later moving to Heatherley Cheshire Home, Copthorne, Sussex.

Ginger was a remarkable person and his gifts were manifold. As war-time pilot, medical student, family doctor, broadcaster, organiser at Heatherley and patient, he made a host of friends. There are many who count it a privilege to have known him and speak with pride from their own knowledge and experience.

Those of us who were privileged to know him well, admired his sense of fun, his zest for life, his deep concern for others and his work with the family at Heatherley. But more than this, we were inspired and humbled by the quiet dignity and courage with which he endured pain and the ravages of illness, a record now legendary among Guy's men and women. Archbishop Ramsey reminded us recently how often the greatest human virtues are born of suffering. There could be no finer example than that shown by Ginger Farrell.

Our lives are richer for having known him, and to his devoted wife Pam and two sons we of the Guy's family extend our deepest sympathy.

D.V.D.

GUY'S DIARY

DECEMBER

12th	M.	1.00	Clinical Lecture. Mr. KINDER. "Injuries of the Urinary Tract".
13th	Tu.	1.00	Clinical Lecture. Prof. ATKINS. "Peptic Ulcer".
15th	Th.	1.00	Clinical Lecture. Prof. POLANI. "Occurrence and Effects of Chromosome Anomalies, with special reference to Spontaneous Abortion".
15th	Th.	5.00	Neurosurgical Round in Clinical Theatre. Mr. MURRAY FALCONER.
16th	F.	1.00	Clinical Lecture. Dr. GRIMBLE. "Sexually Transmitted Disorders".
19th	M.	1.00	Clinical Lecture. Lord BROCK. "Pleural Suppuration".
20th	Tu.	1.00	Clinical Lecture. Mr. READING. "Tumours of the Naso-Pharynx".

Clinico-Pathological Meeting: There will be no meeting in December. The next meeting will be on Saturday, 28th January, 1967.

RUGBY FOOTBALL INJURIES AND THEIR TREATMENT

By

H. C. BURRY and P. HUME KENDALL

During the past 30 years there has been a considerable increase in the popularity of Rugby football in the United Kingdom and as a result there has been a corresponding rise in the number of clubs and therefore participants in the game. At one time Rugby was only played on Saturday afternoons and its devotees were largely those in academic occupations; but now participants from all walks of life play the game on almost every day of the week, and injuries which result in time off work may constitute a serious individual economic problem. It therefore seems a seasonable time of the year to review the types of injury that occur in Rugby football and their management, based on the treatment of patients attending the Department of Physical Medicine at Guy's.

THE MECHANISM OF INJURY

In an excellent review of injuries sustained in Rugby football, O'Connell (1954) pointed out that there are four main phases in the game in which accidents may occur as a result of physical contact between players.

(1) The scrum: Injuries to the head and neck of the players in the front-row are prevalent when the scrum comes together very quickly or collapses. This is the main cause of head and neck injuries; fractures of the skull may occur but are seldom severe. There are usually one or two fatalities reported each year from fracture dislocation of the cervical spine sustained in this way. Forwards tend to suffer most of the injuries around the head and face, particularly the ears. "Binding" in the scrum is also responsible for a number of shoulder injuries, particularly if the scrum collapses.

(2) Tackling: The tackle in Rugby is, in fact, not as dangerous as it looks, as players are taught to fall safely early in their training. The wing-threequarters, however, are quite likely to receive shoulder and leg injuries if tackled when running in full flight. The common major injuries in the lower limbs are sprains and tears of the lateral ligament of the ankle joint and occasionally the interosseous ligament. The medial ligament of the knee joint is most often injured, the lateral ligament rarely. The medial ligament almost invariably tears at its femoral attachment, but is occasionally torn away from its point of attachment to the medial meniscus. This injury usually results from an opponent falling across the lower leg, particularly in the

course of a vigorous tackle from the side. Cartilage tears occur most often when there is a forced external rotation of the flexed knee joint and in this position the cruciate ligament may also be ruptured. This is apt to happen when a player is spun round by a tackle with the foot fixed on the ground. Cruciate ligament injuries are usually only seen in association with cartilage tears.

(3) "Falling on the ball": this is the commonest cause of multiple haematomata from accidental or deliberate kicking in an attempt to free the ball into play. Scrum-halves are quite often severely injured around the head and face when attempting to get the ball back from such loose scrums.

(4) "Line-out": when the forwards jump high with their shoulders and arms extended to reach for the ball, their abdomens and backs are exposed and they are in an extremely vulnerable position if tackled. They frequently fall awkwardly, sustaining shoulder injuries. The commonest shoulder girdle injuries are sprains of the gleno-humeral joint and sprains and subluxation of the acromio-clavicular joint; the latter is exceedingly painful and tends to heal slowly.

Other causes of injury which are more rarely seen result from contact between players with the corner flags and goal posts, particularly when running hard or tackled. Direct blows from the ball may cause injury to the eye and ear or fracture of the finger if the ball is received end on.

INJURIES TREATED

During a one-year period from October 1st—October 1st, a total of seventy-two injuries resulting from Rugby football were seen in the Department of Physical Medicine. These occurred not only in Guy's players but also in players from a number of other clubs who were referred to the hospital.

UPPER LIMBS	
Shoulder—dislocation	2
contusion and muscle strain	16
Acromio-clavicular joint—dislocation	1
strain	2
Elbow—contusion	1
Fingers—traumatic arthritis	4
Thumbs—traumatic arthritis	2
LOWER LIMBS	
Thigh—haematoma of the quadriceps	9
Knee—haemarthrosis	4
meniscus injury	4
ligament injury	3
Calf—strains and haematoma	6
tendo Achilles rupture	1
Ankle—lateral ligament strain	5

TRUNK

neck strain	3
lumbar spine strain	9

These injuries are only those seen in the Department at routine clinics, usually the day after the injuries had been sustained, or on the Monday after a Saturday game.

Major injuries such as concussion, fractures and lacerations were normally dealt with at the time or immediately after the match at the nearest hospital or in the Traumatic Unit at Guy's; although many such patients subsequently came to the Department for rehabilitation they are not included in this series.

TREATMENT

1. **General Considerations:**

One of the advantages of treating athletic injuries of this type is the fact that most of the patients are healthy, physically fit people whose tissues can be expected to respond rapidly to therapy. But if there is this great advantage, there are also drawbacks, namely the anxiety of the athlete concerning his future and the great urgency which exists to put him back on his feet as soon as possible. This anxiety is not always easy for others, including the physician, to understand unless they have themselves participated in highly competitive sport. On the one hand the player is worried about the decline of his physical fitness which must result from enforced inactivity and on the other hand he is concerned lest too early return leads to a recurrence of his injury. If these factors are appreciated by the doctor, he will be able to supply the reassurance which is so necessary, as well as plan his treatment in such a way as to return the player to his team as soon as possible. It is imperative for him to remember that the player's physical fitness may be the product of months of hard work and that he is likely to lose it in as little as four weeks' inactivity.

It is disappointing that many injuries seen at specialist clinics have had improper treatment (or no treatment) in the vital early stages. For example, a sprained ankle which has not been tightly strapped immediately, will swell to two or three times its former size while its owner restores his fluid balance and damps down his pain receptors in the bar after the game, and this neglect may cost him two or three weeks in speed of recovery. Again an enthusiastic "masseur" may have given the player "a rub" to relieve the pain of his torn quadriceps, thereby increasing the haematoma and delaying recovery. Often players will delay seeking help, or their doctor will advise them only to rest and on first attendance they may already have a partially organized haematoma which will take weeks of patient therapy to resolve. It is of vital importance, therefore, that players, coaches, and the medical advisers of teams should appreciate emergency treatment.

2. **Common Injuries:**

(a) *Ruptured muscles.*

Whether the injury results from a blow or failure of fibres to

relax due to cold or fatigue when the muscle is suddenly stretched, or sudden stretching of the actively contracting muscle, the result is approximately the same—torn fibres with or without a torn muscle sheath, spasm of surrounding muscle fibres, and most important, haematoma. It appears that the presence of extravasated blood accounts for the muscle spasm commonly present long after the initial contusion effect has worn off. If the rupture involves superficial fibres and there is a tear of the muscle sheath, the haematoma tends to gather outside the sheath and there is the apparent contradiction of a large swelling and minimal loss of function. Organization of blood clot by excessive fibroblastic proliferation may lead to (a) shortening of the belly of the muscle, (b) adhesions to surrounding structures, and (c) persistence of an extremely tender nodule for many weeks. Occasionally calcification may occur and, rarely, invasion of the lesion by osteoblasts (myositis ossificans) leading to great pain, and spasm.

The treatment of muscle injuries comprises:—

1. Immediate management with rest and pressure bandages to limit haematoma formation.

2. Definitive treatment. After twenty-four hours' rest, treatment designed to speed resorption of the clot and healing of the torn muscle tissue must be initiated. The usual methods to increase vascularity may be employed; these include local heat of which the most effective is ultrasonics, though short wave diathermy is of value if the former is not available, and the promotion of vasodilatation by exercise. Exercises within the limits imposed by pain should be commenced immediately and are an essential part of early recovery. The place of massage is not altogether clear. It is probably valuable in aiding absorption of extravasated blood and overcoming muscle spasm, but there is increasing suspicion that it may predispose to the formation of myositis ossificans occasionally. Rapid progression to active movement is of great importance in ensuring that the muscle heals in a position of maximum function. If union occurs whilst the limb is splinted, fibrous tissue contractures may occur and delay recovery time. For instance, a patient should be running within forty-eight hours of a hamstring tear as long as there is no evidence of a significant degree of rupture. Local infiltration with anaesthetic may be helpful in this recovery stage. This type of active treatment must be limited in the case of quadriceps injuries where there is instability of the knee joint.

Where a complete rupture of a muscle is suspected early surgical repair must be considered.

(b) *Tendon Injuries.*

The situation where a muscle is torn at its origin or insertion is totally dissimilar to that described above. Here the relative avascularity and tendency to chronicity makes secure healing a great problem. Local heat and particularly ultrasonics are very useful and local infiltration with corticosteroids is often the only means of settling a chronic lesion. In contra-distinction to muscle fibre tears, complete

rest of the part is essential for the first week and this period must be followed by the most cautious return to training, with complete rest again if symptoms recur. More chronic lesions may require several steroid injections with supportive ultra-sonics and three or four weeks' rest.

In addition to local treatment, certain drugs may be of value:—

1. *Fibrinolytics.* There is some evidence to suggest that orally or locally injected fibrinolytic agents may speed resorption of the clot by aiding in its permeation through tissue spaces. "Varidase" which contains streptokinase and streptodornase, and "Chymoral" which is a mixture of the tryptic enzymes trysin and chymotrysin are useful examples.

2. *Anti-inflammatory drugs.* Phenylbutazone and oxyphenbutazone have a limited place in the treatment of the tendinous injury but in general drugs in this group, with their ever-present risk of serious side effects, should be avoided.

3. *Analgesics.* These may be indicated where a large, tense haematoma is associated with intense muscle spasm, or in severe joint injuries.

4. *Muscle relaxants.* Relief of muscle spasm may relieve pain and expedite return of function to the injured muscle. Drugs known to be useful in this respect are Carisprodol and Diazepam ("Valium").

(c) *Ligamentous and Joint Injuries.*

Management of joint injuries depends on several factors:—

1. The extent of associated ligamentous injury.
2. The presence of blood in the joint.
3. The presence of injury of other structures, e.g., joint cartilage, muscles, etc.

For the purposes of treatment ligamentous sprains may be subdivided into mild, moderate and severe (Tucker 1956).

For all degrees of injury, the emergency treatment involves the application of pressure bandages and elevation of the part of limit bleeding.

In mild sprains where only a few fibres of a ligament are torn, modified weight bearing may be allowed at once, provided the ligament is supported with a firm bandage. Subsequent treatment includes injection of a combination of local anaesthetic and corticosteroid preparation into the tender area, resolution of haematomata and oedema by use of ultrasonics and massage, followed by active exercises. A mild sprain treated in this way is often completely symptom free in two to three days.

Moderate injuries occur when the ligament is partially torn, for instance, when the ankle is subjected to a forced inversion when running. All cases should be X-rayed to exclude fracture. Weight-bearing should be reduced as far as possible. Large effusions and haemarthroses should be aspirated and local steroids with or without hyaluronidase injected into the joint and ligament. Weight-bearing is permitted when the effusion has subsided and gradual

active exercises started immediately. Recovery usually takes two to three weeks.

Severe degrees of sprain are those associated with a ruptured ligament and an unstable joint. These are usually only seen in the ankle and knee joint.

Where there is evidence of complete rupture of the medial ligament of the knee, there is much evidence to suggest that surgical reconstruction is the treatment of choice, giving a more secure result and speedier return to activity. Surgical treatment of the ruptured deltoid ligament of the ankle is disappointing and follow-up of groups treated by surgery, immobilization in plaster, and by physiotherapy without either of the former, shows little difference in prognosis. When immobilization in plaster is necessary, it is essential that muscle power be maintained by frequent isometric contractions.

More severe tears pose the difficult problem of whether to apply splints or not. Whilst splinting may lead to more secure healing, it frequently leads to adhesions between the ligament and deep structures, and by immobilization causes stiffness of the joint and atrophy of the muscles about it. Each case must be considered on its merits. Where there is any suggestion of instability of the joint, the wisest course is undoubtedly immobilization in plaster of paris.

The treatment of haemarthrosis is immediate aspiration, followed by intra-articular injection of corticosteroids with or without hyaluronidase, followed by pressure bandaging. Corticosteroids undoubtedly minimise the inflammatory changes in the joint and expedite recovery but the very small risk of infection must be borne in mind. The presence of blood in the joint though suggestive of serious damage may only be the result of a contusion of the synovial membrane.

Rehabilitation after dislocation of the shoulder requires a delicate balance between too little activity leading to stiffness of the joint, and too much risking permanent weakness of the joint capsule and recurrent dislocation. Probably early mobilization is best, provided that the arm is not raised above the horizontal plane. Minor injuries of the rotator cuff, of course, usually respond well to local injections of corticosteroids.

Return to Rugby

The resumption of training should be early but gradual, with short sessions initially particularly in the case of leg injuries. Early work should all be carried out on a level surface to minimise the risk of stumbling and aggravating leg injuries. Provided there is no sign of reaction to the work carried out, for instance, effusion, swelling, increasing pain, the training programme can be stepped up quickly. Full match-play should not be permitted until physical fitness has been regained as well as full symptom-free movement of the injured part. Repeated injuries are more commonly seen in the ill, unfit, untrained players, and the prophylactic value of a high degree of

physical fitness is clearly demonstrated by the rapid fall in injury rate after the first few weeks of the season. Don't play rugby to get fit; get fit to play rugby!

Acknowledgments

We are grateful to Miss Jean Jenkins, M.C.S.P., Superintendent Physiotherapist at Guy's, not only for the great care and attention given to the players referred to in this paper, but also for helping to compile the list of injuries.

References

Tucker, W. E. (1956), *Brit. Med. J.*, 1, 515.

O'Connell, T. C. J. (1954), *J. Irish Med. Ass.*, 34, 20.

NOTICES

CHRISTMAS HOLIDAY, 1966

The following arrangements will be in operation for the Christmas holiday.

ADMINISTRATIVE OFFICES:

The Superintendent's Office will be closed on December 25th and 26th but open for urgent business on December 24th and 27th.

The Transport Office will be closed on December 24th, 25th, 26th and 27th, and all requests for ambulance transport required after the holiday should be send to the Transport Office as soon as possible—at the latest by December 22nd. *The ambulance service does not provide transport to take patients home on Christmas leave other than in exceptional circumstances.*

The Department of Medical Social Work will be closed on December 24th, 25th, 26th and 27th.

The Medical Records Department and the Admitting Office will be closed on December 24th, 25th, 26th and 27th.

CLINICAL DEPARTMENTS:

The following departments will be closed on December 24th, 25th 26th and 27th:—

Out-Patient Department
Physiotherapy Department
Diagnostic X-ray Department

The Dental Department will be open for emergencies during the morning of December 24th and closed on December 25th, 26th and 27th.

The Radiotherapy Department will be closed on December 24th, 25th and 26th and open on December 27th for treatment only.

Salomons Centre will be closed on December 25th and 26th and open during the afternoon of December 27th.

No departments will be open on the 25th and 26th December other than the Accident and Emergency Department.

PHARMACY:

The Pharmacy will be closed on December 25th and open on the 26th and 27th from 9 a.m.—12 noon. There will be a limited ward basket collection and delivery on December 26th and 27th, but all stock requirements should be anticipated as far as possible during the preceding week.

C.S.S.D.:

The Central Sterile Supply Department will be closed on the 25th and 26th December. The Department will be open during the morning of Decmber 27th.

Orders for delivery on the 24th December should include packs required for December 25th and 26th.

Orders for delivery on the 27th December must be received by 7 a.m. from Hunt's House and by 11 a.m. from New Guy's House. (Usual Saturday morning arrangements.)

OPERATING THEATRES:

The main operating theatres will be dealing with emergency operations only from December 24th to 27th inclusive.

R. J. CANN, *Acting Superintendent*

Cricket Club A.G.M.

The Cricket Club A.G.M. was held on Monday, November 28th. The President, Mr. F. N. Glover, was in the chair.

The President and Vice-Presidents were re-elected unanimously.

The following officials were then elected for the 1967 season:—

Captain—M. Appleby.

Vice-Captain: J. Butchey.

Secretary: R. Clark.

Treasurer—R. Beecleash.

Captain, 2nd XI—R Kendrick.

Bats were awarded to J. Butchey and S. Davoodbhoy for heading the batting and bowling averages respectively. The Trist Cup was awarded to J. Butchey.

Wanted—Orchestral Players

Musica Medica, which played at the concert in Southwark Cathedral last Wednesday, needs more players: strings, clarinets, flutes, bassoon. Our next concert has been planned to include these instruments in addition to existing players.

Rehearsals, 8—10 p.m., Mondays, in the Quiet Games Room.

Please contact Michael Vellacott (leader) or Michael Coe if you are interested.

REPORTS

Debating Society

"This house welcomes computerised courting"

As the coffee cups clattered to silence, the house rose to its feet and divided —to allow passage to the ceremonial procession of the chairman and his guests. The house sank back into its rubber foam cushions and at the ring of a gong (instead of the push of a button) computors, computed and non-computed, sparked and crackled from proposition to opposition to floor, and even a few passing flashes at the chairman (R. Davis). The men and women of science and technological progress (Dr. W. L. Gent and Miss Maria Tihanyi—Guy's) were unable, however, to tie the possibly happier romantic advocates of time-honoured agony and ecstasy in courting, in miles of punched tape and questionnaires. The visiting side (Dr. O'Connel and Mr. P. Miller—Charing Cross) carried the day—a substantial majority preferred untechnological methods of trial and error to computers '66. A happy defeat perhaps in this highly automated age: "This house does not welcome computerised courting".

D. N. Morton

"Bring-and-Buy" Sale

Due to the kind hospitality and generosity of Mrs. Clarkson, a most successful Cheese and Wine Luncheon with "Bring and Buy" Sale was held at Mrs. Clarkson's house on the 24th November.

After a delicious cup of hot soup, the wonderful selection of cheese made a most appetising meal. Many attractive and useful presents were brought, and everything was sold in a very short time, making the very satisfactory sum of £93 1s. 9d. for the funds of the Guy's Hospital Ladies' Association.

CORRESPONDENCE

Postgraduate Education at Guy's

SIR,—Many will agree with Passim's wish (26th November) for more postgraduate education at Guy's, particularly in the form of organised meetings. The inference, however, that the newly instituted residents' weekly seminar marks the beginning of effective postgraduate meetings at Guy's is a little misleading, as, for instance, last week's activities indicate:—

Monday—12.30 to 1.30 p.m.: Registrars' Meeting. "Interesting X-rays," Dr. Saxton (Department of Surgery).

Tuesday—8.05 to 9 a.m.: Orthopaedic Radiological Meeting (Medical X-ray Dept.).

Wednesday—1 p.m. to 2 p.m.: Cardiac Meeting (4th floor, Hunt's House).

Thursday—1 to 2 p.m.: Immunology Meeting (Pathology Library).

Friday—1 to 2 p.m.: Radiology Meeting (Medical X-ray Dept.).

As Passim has not heard of these activties, it presumably classifies them as "unenviably clandestine exercises" even though some residents do participate. Moreover, 50 written invitations are sent out weekly for the Monday registrars' meetings, which have been held for several years and at which coffee and biscuits are available. The Tuesday X-ray meeting may be regarded as unenviable *and* clandestine by those who are still in bed at 8 a.m. The cardiac meeting has been held for many years and is so well attended that it is difficult to obtain a seat. Perhaps Passim should have realised that part of the fault may be that some people are a little shy at broadcasting their efforts at postgraduate education and may not have realised that these efforts even warranted such a title.

There is little doubt that we need more organised postgraduate education and more advertisement of what is already going on. To this end a list of meetings is now published in the Colonnade every week.

Yours, etc.,

I. McColl.

Guy's Hospital, S.E.1.

[On behalf of those who have found the above meetings as clandestine as we, we welcome the above information. We trust that any who may be shy of revealing similar information will now take heart and will add their bit to the new notice in the Colonnade.—*Eds.*]

Resuscitation of the Newborn

SIR,—It was with interest that we read the survey of Resuscitation of the Newborn by Mr. E. A. Williams in the *Gazette* of 29th October, 1966. While appreciating that this article was intended as a historical note, we feel that the ommission of the latest methods of resuscitation was perhaps misleading.

In order to avoid any possible confusion in an undergraduate publication, we would like to add that the work of Haighton and Blundell at Guy's foreshadowed not only the method of intra-tracheal insufflation described by Blaikley and Gibberd in 1935 but also, and even more directly, the currently accepted practice of intermittent positive pressure respiration used in resuscitation of the newborn.

Yours, etc.,

G. Gerson
M. Lindsey
P. Smethurst
R. Watkin

Department of Anaesthetics,
Guy's Hospital.

7-day Week

SIR,—Running the Hospital on a 7-day basis instead of a 5½ day week, sounds an idea that deserves closest consideration from all of us.

Have you information as to whether increases of staff were needed for the departments (clinical consultants, laboratories) that were opened for this project?

If the hospital where the project has been tried was able to take an extra 1,000 patients a year, the scheme sounds practical, even if it would take a good deal of planning.

Yours, etc.,

R. C. MAC KEITH.

Guy's Hospital, S.E.1.

Dental Education

SIR,—I read with great interest your article on the Dental Curriculum, on which I have fairly definite views. I must take issue with the author when he apparently wants to reduce the time spent on prosthetics. While nowadays I hardly ever do any mechanical work myself, on rare occasions I am very glad to know what to do in a prosthetic emergency. I would add that many mechanics to the profession are driven nearly frantic by the unreasonable requirements of opinionated dentists who appear to have the haziest notions of the properties of the materials they are using.

How right your author is on the fragmentation of the course. We have had here a large number of assistants, young and capable, and we have been happy to pick their brains; but they have all suffered from the same disability, which seems widespread, of being unable to see the wood from the trees. Far too many dental surgeons seem to look at one tooth at a time, deal with it and move on to the next, seemingly incapable of viewing the whole mouth, let alone the whole patient. For this I blame the gentlemen who plan the curriculum, and I would like to see final year students given patients with instructions to do everything necessary, including prosthetic work, and a three or six months' follow-up; and to try and get to know the patient a little, and his circumstances and attitudes, both of which are highly relevant to dental treatment.

Yours, etc.,

E. C. HAMMOND

62, Benhill Avenue,
Sutton, Surrey.

SIR,—As an interested observer of the dental scene, I have read, with care, your articles upon dental education and its ensuing correspondence.

It appears to me that most members of the dental profession are too involved in current controversies to form objective views. May I then ask a few of the questions which have occurred to me over the last five years?

Are there accurate assessments of the present requirement for oral health in the general population, and is it possible to predict the future trend of this statistic?

What percentage of the general population require " advanced treatment " with regard to restorative dentistry, orthodontics, etc?

Is it necessary to take five-and-a-half years to train a dental surgeon to do the simpler tasks in dentistry, e.g. small amalgam fillings, constructing acrylic dentures?

What is the relative cost of training an auxiliary to that of a dental surgeon, when considering their practising life and production?

Is it not true that dental auxiliaries can only be recruited from a diminishing pool of labour; already the demands of commerce, and of factory, have produced an acute shortage of nurses?

If the employment of auxiliaries is deplored in this country and yet allowed in developing countries, does this not suggest a double standard and perhaps double thinking?

I feel that the future of dentistry must be planned considering these points, and equally the dental curriculum must be constructed with more than the production of "a good general practitioner" in mind.

Yours, etc.,

PETER SIMS

East Wing,
Guy's Hospital.

We'll Keep a Welcome, Perhaps

SIR,—Being so far away, I receive my Guy's *Gazette* rather later than most, and I cannot understand why Dr. Tudgay wrote such a rude, pointless anti-Welsh letter to the *Gazette*. Perhaps he would like to stop the Irish, Scots and Commonwealth students entering Guy's as well. This would produce a very dull student intake, and not only would Guy's lose its name in the world of medicine and dentistry, but also the world of sport. Perhaps Dr. Tudgay was kept out of the 1st XV by a Welshman, or was unable to join them in good voice on a Saturday evening. Whatever the reason, if he writes to the *Gazette* again, I do hope it will be a letter containing something in better taste.

Yours, etc.,

DAVID MATTHEWS.

Royal Air Force,
Episkopi, Cyprus, B.F.P.O. 53.

Sport Support

SIR,—Some may have noticed the encouraging progress of the first XV this season, but the tremendous effort put into a match by the individual members of the team is not easily appreciated. A high standard was set by the South Africans in the 1920s, and since then our first XVs have been striving to maintain a great tradition. Support from the stand and touchline is a great encouragement which unfortunately has been sadly, even embarrassingly, lacking during past years, and it is not unusual for Guy's to play important matches before a handful of spectators. This is discouraging for us as well as for our visitors, and it is hardly surprising that we have lost valued fixtures.

May I ask both staff and students for their support.

Yours, etc.,

J. S. BATCHELOR
President, Guy's Hospital Rugby Football Club.

78, Harley Street,
London, W.1.

Rose Ball

SIR,—Guy's Hospital Clubs' Union Annual Rose Ball will be held in the Lancaster Room of the Savoy Hotel on Friday, 20th January, 1967. Ballroom music will be provided by Laurie Payne, his band and Joan Anderson. During the evening the famous Tropicanas will also be playing and will have with them Angela Gully, who will give an amazing display of Limbo Dancing.

Double tickets, at 4½ guineas, will be obtainable from me, and others, as stated on the posters around the Hospital. I would be grateful if applications for tickets could be accompanied by an indication of any preferred table arrangements. Please apply as early as possible, since demand is likely greatly to exceed supply.

Yours, etc.,

JONATHAN H. WILLIAMS.

Guy's Hospital,
London Bridge, S.E.1.

Priest and Patient

SIR,—It was with great interest that I read in the *Guy's Hospital Gazette* of the 12.11.66, the article by Fr. A. C. Fraser, R.C. Chaplain to the Hospital entitled " Priest and Patient." I hope that all nurses and students have read it.

In over 70 years of life I have, on several occasions, had illnesses and at times moments of peril, and I have never found the visit of the priest in the least bit alarming; indeed he has always been comforting. During the last war my Captain always had the ship's company piped to prayers on going into action. As senior Catholic Officer it was my privilege to say prayers with and for the Roman Catholics, and I think we always felt comforted. It took fear away, but then Catholics are accustomed to speak of death many times a day. Familiarity does not breed contempt of death, but enables us to approach the inevitable philosophically and with resignation.

I wholeheartedly agree with every word that Father Fraser has written and thank him for it.

Yours, etc.,

ST. GEORGE B. DELISLE GRAY.

" Lisheen ", Grange Road,
Buckfast, S. Devon.

Non-Graduate

SIR,—I read with interest the Nursing Section in the *Guy's Hospital Gazette* dated 26.11.66. I would like to point out, at the risk of appearing pedantic, that only a minority of nurses are University graduates.

It is, therefore, incorrect to write of post-graduate education for nurses, but rather post-registered.

Yours, etc.,

C. M. HUBBLE, S.R.N. (Mrs.)

Gatewood, 42, Douglas Crescent,
Thornhill, Southampton
(West End 2137).

Ginger Farrell

SIR,—His friends will remember Ginger Farrell, in disability as in the gaiety of youth, as a man who represented the fulness of life—deeply, abundantly, vitally. He would surely see his own memorial in those living, whom he loved and left behind.

A number of his friends have suggested that we could best express our sympathy and affection for Pamela and the boys in practical terms. There may be others with whom we have lost personal touch who would wish to join in this.

Contributions will be welcomed therefore—to Jimmy Goodliffe at Guy's, please, and before January 10th, 1967.

Yours, etc.,

PRUE AND DAVID TUNNADINE.

Grove House,
Leighton Buzzard,
Bedfordshire.

CRITICISM

Winter Art Exhibition, 1966

The Art Society exhibition in the Gordon Museum was somewhat earlier in the college year than is usual. I imagine this accounted to a certain extent for its diminished size. This was certainly a smaller exhibition than the one held last spring and with obvious exceptions not of such a high standard.

Of the work exhibited, the paintings of Neil Watson were outstanding, and the pottery of Henrietta Pels and the sculpture of B. A. Wooster were well above the general standard of the rest of the work shown. This, for the first time, made the Art Society's decision to award prizes a simple matter.

Neil Watson's pen and wash has, if anything, improved since last year. There was one exceptional view of St. Paul's and a beautifully composed "College Street". "Shrimp Market, Ostend", was a study of figures rather than buildings, and showed that he could capture their character and mood as well as in his more architectural studies. "Madeliene Paris" was a particularly lively pen drawing. Two more experimental works using paint to mould and move as well as colour were "Ships at Anchor", in powerful yellows and reds which I found entirely successful, and "Les Sables Dolonne", which somehow missed.

Henrietta Pels again exhibited several pieces of satisfying stoneware. Her oil landscapes are also very competent and convey a good feeling of solidity with some nice effects of light and shadow.

There were two works by B. A. Wooster in the exhibition, a relief panel which was not exceptional, and a small abstract sculpture which was one of the few pieces in the exhibition in the modern idiom. This complicated but solid structure stimulated a desire to touch as well as look. It will be interesting to see more of his work in future exhibitions.

Another artist with a more experimental approach was Chris Side, with an interesting abstract painting, "Timber", and a relief panel, "Destruction". I feel that his work would gain from being on a larger scale. There was a group of water colours by W. H. Kinder which showed an extremely able handling of a difficult medium.

I liked an interesting pen drawing of "Roof Tops Near Kings Cross", very solid and full of pattern by Tom Treasure; also his small oil, "Hands". There were some impressionistic paintings by W. Mann which showed a strong Monet-Turner influence. Several oils by Peter Ticehurst, centred on water, were interesting composition but failed to show any feeling for the actual water. A large group of work was exhibited by Mona Van Essen. Her wash, "Nude", showed considerable sensitivity but her child studies tended toward the sentimental and stylised.

The case of jewellery by Robert Oxlade stood somewhat on its own. Some of it was attractive, modern and very wearable, which is what jewellery should be. Some had a more lasting quality, particularly a pair of silver ear-rings based on a square which, if larger, would have made an interesting piece of sculpture.

Looking at the exhibition as a whole, I feel there is a surprising lack of experiment, particularly in style and materials; perhaps a visit to the newly-arranged modern room at the Tate would stimulate some ideas. I am also surprised that so little of hospital environment gets into its art; surely all that pattern and texture in the glass bottles of the Gordon Museum has some effect. I believe there is to be a second exhibition in March—perhaps there will be more exhibitors and a greater variety of styles.

MARGOT CAMERON.

NURSING SECTION

AUXILIARY NURSES.

The latest number of Auxiliary Nurses employed by the Hospital is now put at 24. Many of these nurses have experience and may even be qualified in their own countries. They are not allowed to practise as Registered Nurses in this country because they do not fulfil the General Nursing Council requirements either due to language difficulties or to some other problem. There are at present nine nurses from Finland working as auxiliaries, three from Sweden, one from Spain, one from Germany, seven from the West Indies, two English nurses, and one from Morocco. Guy's auxiliaries can be said to be truly a League of Nations.

UNIFORM DILEMMA.

Publications at the beginning of last month were full of the winning entries in the Nurses' Uniform Design Competition. It was a pity that there was no professional representation amongst the panel of judges.

The winning designs appeared modern but rather impractical. The skirts were cut straight, allowing limited movement; there were small pockets which were inaccessible, and there appeared to be no pen pockets at all.

Oddly enough there was no mention of aprons. Anyone who has worn an apron for longer than a day knows how dirty and creased it is by the second day. If the uniform designers wanted a dress a day, then one must presume that they were to be made of unshrinkable, easily washable crease resisting material. If these designs are to be taken up by hospitals for their nursing staff uniforms, then it would be interesting to work out the cost in terms of numbers and durability of dresses.

HOSPITAL HYGIENE.

There have recently been comments on the decline in Hospital hygiene. Because there appear to be fewer people on their hands and knees scrubbing for dear life as in years past, it does not mean that hospitals are no longer clean. Ward design, and advance in cleaning materials and machines mean that less manual labour is involved. It is a pity that the noise of the machine allows the patient no rest.

STAFF CHANGES AND APPOINTMENTS

APPOINTMENTS

S/N G. D. Baker, S.R.N. (Provincial Hospital, Paarl, S. Africa), to the Evelina Hospital).

S/M G. Orme, R.G.N., S.C.M. (Western General, Edinburgh), to Victoria.

S/N M. O'Reilly, S.R.N. (Frere Hospital, E. London, S. Africa), to Casualty.

S/N D. H. Thomas, S.R.N., R.M.N., to York Clinic.

DEPARTURES

S/M G. Francois, from Victoria Ward.

S/N C. Hunter, from Wilks Ward.

S/N D. Hall, from Nurses Sick Room.

S/N L. Milne, from Main Theatres.

Time Table of Events at Guy's Christmas, 1966

FRIDAY, 9TH DECEMBER	
7.30 p.m.	Students' Christian Union Carol Service in the Hospital Chapel.
FRIDAY, 16TH DECEMBER	
7—8 p.m.	B.B.C. Carol Singers.
TUESDAY, 20TH DECEMBER	
8.30 p.m.	Service of Carols and Nine Lessons in the Hospital Chapel.
THURSDAY, 22ND DECEMBER	
4 p.m.	Dressers' Teas and Ward Decorations.
6—7.30 p.m.	Carols by the Southwark Cathedral Choir. Party "A", Hunts House, Nuffield House, and York Clinic. Party "B", New Guy's House.
FRIDAY, 23RD DECEMBER	
4 p.m.	Dressers' Teas and Ward Decorations.
8.30 p.m.	Free Church Communion Service in the Hospital Chapel.
SATURDAY, 24TH DECEMBER	
11.30 p.m.	Midnight Eucharist in the Hospital Chapel.
SUNDAY, 25TH DECEMBER	*Christmas Day.*
6—7 a.m.	Nurses' Carols in the Wards.
7—7.30 a.m.	Nurses' Breakfast in the Nurses' Home.
7.15—8 a.m.	Sisters' Breakfast in the Nurses' Home.
8.30 a.m.	Holy Communion, Hospital Chapel.
10.30 a.m.	Morning Service, Hospital Chapel.
12 mid-day	Patients' Christmas Dinner
1—2 p.m.	Resident Domestic Staff Dinner in Tabard House.
1 p.m.	Nursing Staff Christmas Dinner in the Wards.
3.30—4.30 p.m.	Patients and staff—Tea in Wards.
7.30—8.30 p.m.	Nurses' Supper in the Wards at the Sisters' discretion. All Day nurses to be off duty and out of the wards by 10.30 p.m.
MONDAY, 26TH DECEMBER 2—4 p.m.	Visitors' Teas in the Ward.
1967	
FRIDAY, 6TH JANUARY	Sisters' Dinner at the Clothworkers' Hall, Mincing Lane, London, E.C.3.
THURSDAY, 12TH JANUARY	Staff Nurses' and Staff Midwives' Dinner in the Nurses' Dining Room.

DEPUTY MATRON

SPORT

RUGBY FOOTBALL

Guy's came back to business with a bang after their two-week break, defeating Cheltenham 8—5 and a Buckinghamshire County XV by 35 points to 3.

The Cheltenham match was virtually a forward battle all the way through, and as such the West Country side won hands down. The Guy's pack were badly beaten in the tight, beaten in the line-out, and came out fairly equally in the loose. It must be a long time since the Guy's pack were so outplayed as in this game. Hence it can be gathered that Guy's were a little lucky to win this game. However, they were not as lucky as the Press and B.B.C. made them out to be; Guy's took what chances they had, Cheltenham did not. As far as the B.B.C. making some sarcastic comment about there being 42 people to watch the game, if someone had mentioned to them the terrible conditions under which the game was played, then no such comments would have been necessary. For the last thirty-five minutes the spectators needed arc lights to really see what was happening!

Against the much weakened Buckinghamshire side, the Guy's backs had a field day, scoring eight tries between them. It was a great shame that Buckinghamshire did not have a full side, which would have included at least two internationals, Laughland and Ashby, as Guy's would then have been more severely tested.

Last Saturday Guy's came up against Streatham and Croydon, one of their bogey sides of recent seasons. Yet again Guy's were unable to lay the bogey by losing by three points to nil. Unfortunately Guy's were reduced to fourteen men when Curson fractured some ribs early in the game. Thorburn was absent because he was playing in the Scottish trial at Murrayfield. Swift, Guy's first choice scrum-half, will be out of the side for quite a lot longer because a knee injury sustained earlier in the season has recurred.

With Christmas approaching, and the Cup matches soon afterwards, it may be said that Guy's must be favourites to retain the Cup won last year after a final replay with St. Thomas's. Guy's have virtually the same side as last season, but are playing so much better than eight months ago. Their first half to the season has been most successful with nine wins in the thirteen matches, and scoring 177 points to their opponents' 83. All in all, everything points to a Guy's win in the Cup final next March, but there again, anything can happen.

HOCKEY

After recovering from a not too good a start to the season, Guy's have slumped very badly of late, losing all their club matches, and also being knocked out of the Cup.

In club matches, Guy's lost 5—0 to Merton, in a game which was far less one-sided than the score suggests, and by 3—0 to Bexleyheath.

After defeating the Westminster 5—0 in the first round of the Cup, Guy's hopes for the Cup were raised. In the second round, Guy's came up against the London Hospital. In a very fine close game, both sides earned great credit in a 2—2 draw. In the replay, Guy's unfortunately did not play as well as they might have done, and went down by 2—0. This is a great shame as the team was promising a good cup run.

SOCCER

After an opening few weeks to the season when Guy's could do little right, the first XI have come along by leaps and bounds of late. In their first Hospitals Cup match against Charing Cross, Guy's finished easy winners by 6—2.

They have also registered their first double figure score of the season, defeating Royal Dental Hospital 10—0.

However, in the University of London Cup, Guy's were defeated 2—0 by the strong Queen Mary College side, which is a fine performance by Guy's.

GOLF

We must congratulate the Golf Club on retaining the Hospitals Cup on November 30th by defeating Bart's by $3\frac{1}{2}$ to $1\frac{1}{2}$ at the Royal Berkshire Golf Club. This result maintains the high standard of golf at Guy's in recent years.

DIARY

RUGBY FOOTBALL.

December Sat., 10th—Old Cranleighans. Home. 2.30 p.m.
Sat., 17th—Esher. Away. 3.0 p.m.
Sat., 24th—
Mon., 26th—Staff v. Students.
Sat., 31st—Old Merchant Taylors. Away.

January Sat., 7th—
Sat., 14th—Plymouth Albion. Home.
Tues., 17th—St. Mary's Cup (2nd Round).

HOCKEY.

December Sat., 10th—South Essex. Away.

SOCCER.

December Sat., 10th—Old Malvernians. Home.
Wed., 14th—Middlesex Hospital. Away (U.H. League).

REPORTS AND RESULTS

RUGBY FOOTBALL

GUY'S v. CHELTENHAM

At H.O.P. Saturday, 26th November
Result: won 8—5

Guy's, without a game for the past fortnight, kicked off thirty-five minutes late, because of the late arrival of the Cheltenham side, on a mild afternoon at H.O.P. As they have in their past few games, Guy's began very briskly, but the pattern of play was largly set by the Cheltenham halves, who seemed completely unable to put away their threequarters in any sort of attacking move, and were content to play to their strong heavy pack.

In the forwards, Cheltenham, with their greater power, tended to control the set pieces and also prevent Guy's obtaining any good, loose ball. There were, however, exceptions. A good jump by Cockburn at the lineout allowed Rowlands to kick diagonally across the field for Price and Beacham to take on. When stopped, the Guy's pack was quickly up in support, resulting in the best loose heel of the match. Ross received the ball on the left wing, and in a determined, skilful run to the line, beat four men to cross near the posts. Elliott converted. The game then developed into a touchline battle with Cheltenham gaining most of the possession and Guy's relieving the pressure with good kicking, especially by Elliott and Rowlands. On the occasions that Guy's did attack, however, they looked very dangerous. Ross made fully 70 yards after being put away beautifully by Osborne, and Rowlands was stopped ten yards short of the line, after a fine break.

The second half continued as had the first with Guy's looking the more dangerous side, but with Cheltenham having the edge up front. After about ten minutes of the second half, Cheltenham worked their way up the field to be awarded a scrum under the Guy's posts. Hey heeled the ball, but the Guy's pack was retreating, and with the ball still at the feet of the Guy's second-row, the Cheltenham scrum-half dived, into the scrum to score an unusual, but effective, opportunist try which was converted.

The game continued at the same level and looked certain to be drawn, until with about eight minutes to go, the Guy's pack came into it own, forcing Cheltenham into mistakes. This resulted in Osborne going very close with a penalty from 45 yards, and then Elliott kicked the winning penalty, ten yards in from touch, on the "twenty-five".

This gave Guy's a win which they just deserved, but the Guy's pack was well beaten in the set pieces. The push in the scrum must be lower if Guy's are to hold their own against heavy opposition. Protection at the scrum-half at the lineout must be improved if our halves are not to be hurried into mistakes.

Team: D. R. Elliott; J. R. M. Ross, D. J. Osborne, R. J. Beacham, J. Price; B. J. Rowlands, B. W. R. Moore; E. Neville, G. B. Hey, A. J. Kingdon, R. A. C. Hughes, J. M. Cockburn, C. W. Thorburn, H. C. Sharp, D. A. Curson.

C. NEVILLE

HOCKEY

First Round Cup match

GUY'S v. WESTMINSTER

At H.O.P. Wednesday 16th November
Result: won 5—0

On a very cold day at H.O.P., Guy's beat Westminster Hospital 5—0 to put them through to the next round of the Inter-Hospitals' Senior Hockey Cup.

Westminster had a relatively weak side, and the game, as far as Guy's were concerned, was one of lost chances. Guy's have found two wings this season, Cripps and Brooks, who can put across good centres, but sadly on many occasions there was no one in the middle who could score from them.

Guy's harassed the opposition for the first ten minutes and two goals resulted. One was by Appleby from a good cross by Brooks and the other by Dodd, after a skirmish in the goal-mouth.

These two goals upset Westminster, and Guy's were then on top until half-time. Two more goals came in the first half. One was an individual effort by Cripps, and the other came

from a good through pass from Appleby, from which McMicham scored.

The second half was far more scrappy than the first. Guy's seemed to relax and as a result passes went astray. However, the team as a whole played well together. This was largely due to the examples of Appleby and J. Crafts, both of whom showed excellent stick work and general hockey sense.

The defence was rarely taxed, but when under pressure tended to show signs of panic.

The final goal came from a goalkeeper's mistake, which Cripps was quick to pick up.

Guy's have a potential cup-winning side this season, and if they can score from their opportunities in the circle,. particularly short-corners, which will not come so freely in coming rounds as they did in this match, then there is no reason why they should not return the Cup to Guy's this winter.

M. KNIGHT

Second Round Senior Cup

GUY'S v. THE LONDON

At H.O.P. Wednesday, 23rd November
Result: drew 2—2

This was a typical Cup game between two evenly matched sides, which provided fast, exciting hockey on a cold grey November afternoon at H.O.P.

For Guy's, J. Crafts was outstanding at centre-half and Appleby often demonstrated his fine stickwork and ability to beat a defender at speed. It is a pity that so many of his resulting shots at goal are just fractionally off target.

Pearson, at left-half, often showed some fine touches, and A. Brooks and H. McMichen, two freshmen to the 1st XI this season, also turned in good performances, which augurs well for the future.

Guy's were in command for the first half and led 1—0 at the interval; a good reverse stick shot by Appleby.

In the second the London equalised after a miss hit by D. Crafts found the Guy's defence too far up and left the opposing centre-forward with just the other full-back and the goalkeeper to beat. This he did, and not much afterwards he put the London into the lead by converting a cross from the right which found the Guy's defenders at sixes and sevens.

All seemed lost, but Appleby spurred his team into greater efforts and finally Guy's equalised when Appleby finished off a good move from the right late in the second half.

Extra time did not achieve any result though Guy's came the nearest to it when Pearson almost scored in the dying seconds, but his shot unfortunately was deflected round the post.

It was very pleasing to see one of the Vice-Presidents supporting this game and for taking such active interest in the Club team.

D. C. E. LOADER

GUY'S v. MERTON

At H.O.P. Saturday, 26th November
Result: lost 0—5

Guy's did not deserve to win this game, but they most certainly did not deserve to lose by five goals. The defence as a whole had an unfortunate day; two of their goals were the direct result of defensive slackness, and one was scored from a mysterious short corner. The Guy's attack played quite well together, and with a little more luck in front of goal would have scored two or three times.

In spite of only having ten men for the first quarter of an hour, Guy's did most of the attacking, and were several times only thwarted by some fine goalkeeping. At this stage, a short corner was awarded against Guy's, from which Merton scored. The Guy's play deteriorated from then on, and Merton scored four more times.

A disappointing result, then, but the team will play worse than this in future and win; the ball did not run kindly for Guy's—it was just one of those days!

Team: N. White; M. Vellacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, H. McMichen, N. Dodd, M. Appleby, S. Cripps.

M. I. APPLEBY

Hospitals' Cup—Second Round replay

GUY'S v. THE LONDON HOSPITAL

At H.O.P. Wednesday, 1st December
Result: lost 0—2

Guy's were knocked out of the Senior Cup by the London at the second attempt. On the day, there was no question that the better side won; the London played the more thoughtful, constructive hockey, adapting themselves well to the muddy conditions.

Taking the game as a whole, the Guy's defence played well, with Kendrick and D. Crafts outstanding. The attack did not create many chances, being generally too slow in thought and action to outwit the London defence.

Guy's started promisingly, and were on top for the first quarter of the game. However, though there were some near misses, especially one fine effort by Dodd, this period of superiority was not turned into goals. After this initial phase, the London came more into the game, and a goal-less draw at half-time was a fair reflection of the play.

After the interval, the London, well prompted by their insides, Desmond and Lawson, a Scottish international, got well on top. Most of the play was in the Guy's half; the Guy's defence came under heavy pressure, and were unable to serve the forwards, who in turn became unco-ordinated.

The London went into a deserved lead when their centre-forward picked up a right-wing cross and scored. Though Guy's rallied, the London remained in control, and scored a second goal following a rebound from White's pads.

Two goals down with ten minutes left to play, Guy's played some determined hockey, but all they could manage was a short corner by J. Crafts that hit the post. A disappointing by fair result; Guy's were beaten by a slightly better all-round team.

Finally, I would like to thank all those people who have braved the elements to support the team in the Cup this year.

Team: N. White; M. Vellacott, D. Crafts; R. Kendrick, J. Crafts, C. Pearson; A. Brooks, H. McMichen, N. Dodd, M. Appleby, S. Cripps.

M. I. APPLEBY

LADIES' HOCKEY

CUP MATCH v. ST. THOMAS'S HOSPITAL

At Cobham Wednesday, 23rd November
Result: won 3—1

As the Guy's team has improved greatly this term, the outlook for this first Cup match seemed quite promising. On the day of the match, we fielded our strongest team, most of whom had played several matches together. Very little time was wasted in settling into the game, and soon the St. Thomas's goal was under pressure.

A very effective break by the St. Thomas's centre-forward resulted in an early goal, but the Guy's forwards soon equalised.

The entire forward line was playing extremely well; passing and covering between individual players was excellent. Only one criticism is possible—some time and effort was wasted by a failure to recognise other members of the Guy's team! The defence were able to function effectively, as every clearance from them was converted accurately to a fast attack. special praise to the right inner and wing, whose speed with the ball felt the opposition far behind.

The half-backs and back switched quickly from defence to attack, and covered well for the forwards.

Guy's won this match by keeping up the pressure until the final whistle, and by superior team-work. The standard of play augurs well for the future.

Team: S. White; R. Thorburn, Rani; M. Fortnam, A. Collins, D. Evans; R. Dow, K. Thorne, L. Hogwood, I. Cormac, F. Griffiths.

Umpire: Mr. Tony Sutherland.

S.J.W.

SOCCER

United Hospitals' Cup, Second Round

(Holders: Guy's)

GUY'S v. CHARING CROSS

At H.O.P. Saturday, 26th November

Result: won 6—2

Charing Cross kicked off on a rather dismal afternoon and immediately were in trouble. Guy's, playing under the observation of their President and Vice-President, clicked into gear and turned on a twenty minute bout of constant pressure. The Charing Cross defence was split wide open, but miraculously their goal stayed intact.

Eventually Guy's got the goal that had to come, as up to now Charing Cross had been playing with ten men. A visiting defender kicked off his goal-line, and after a scramble Lindridge made sure as he maliciously crashed the ball high into the net.

The game continued in a similar manner, and all credit goes to the Charing Cross defence for their determination. Poole finished off another attack to give Guy's a well earned 2—0 lead at half-time.

Guy's began the second half determined to get just reward for the fine attacking play they were producing, but a breakaway by Charing Cross brought them a text-book goal. This shook Guy's and Charing Cross now took the incentive and their resulting hard play gave Guy's a free kick five yards outside their penalty area to the left of the goal. A wall of determined defenders lined up in front of the back covering the left hand side of the goal, and Guy's attack was clustered around the far post.

Lindridge strolled up to take the kick, and instead of the expected "floater" to the far post, he let fly with a fierce rising shot which cleared the wall of defenders and curled into the top left corner. Nobody moved—it was a fantastic goal. Lindridge showed his pleasure with a professional gesture reminiscent of Denis Law.

This goal grought great spirit to the side, but within minutes Charing Cross pulled back another goal, making the score 3—2. There were obvious signs of a goal spree from either side as it had now begun to rain, making the pitch very slippery. This was the critical time. For fifteen minutes both sides batled against each other, and it was left to Elias to break the tension. He collected the ball in his own half, and with a brilliant solo effort beat two men and masterfully shot passed the advancing goal-keeper to give Guy's a 4—2 lead.

Poole and Elias each scored again before the final whistle to give Guy's a stirring victory.

This successful defence of the Cup gives the Club high hopes of winning it again for the third time in four years.

Team: M. Carter; R. Davey, P. Evans; R. Lovell, I. Nash, S. Watt-Smith; D. Jacobs, S. Poole, E. Elias, D. Windridge, I. McClure.

M. K. WATSON

GUY'S v. ROYAL DENTAL HOSPITAL

At H.O.P. *Wednesday, 30th November*

Result: won 10—0

It wasn't until we met our distinguished banana-ball colleagues in the dressing room, fresh from their conquest of Bucks by 35—3, that we began to doubt that we had produced a respectable rugby score. Just as humbling is it to admit that whereas Guy's fielded a side boasting as many members as F.A. rules permit, R.D.H. played throughout with as many men as were the goals they presented us with.

It is pleasing to record that this was Guy's ninth victory in the last ten outing. Nevertheless, the team must beware lest easy victories such as this engender a series of individualistic efforts which, though largely successful in this context, will be sadly out of place against more substantial opposition. Another attempt at constructive criticism (for how else are we to profit from this game?) is that the defenders must maintain greater cohesion by refusing to be drawn out of position though under pressure. Perhaps more assistance from the front men, not least your correspondent, is a major missing factor in this department.

For the record, goals were scored by Jacobs (3), Elias (3), Lindridge (2), McClure (2).

Team: M. Carter; R. Davey, P. Evans; S. Poole, I. Nash (Capt.), R. Lovell; D. Jacobs, E. Elias, I. McClure, D. Lindridge, T. Dutta.

ELWYN ELIAS

London University Cup, First Round

GUY'S v. Q.M.C.

At Brentwood. Saturday, 3rd December

Result: lost 2—0

Guy's approached this game with a great deal of apprehension as Queen Mary College are one of the top teams in the Premier Division of the U.L. League. However, the Hospital side, with nine wins out of ten games, looked forward to a very close game, but knowing that the defence must tighten up considerably.

Q.M.C. kicked off in very wet conditions, the pitch quickly turning into a quagmire. For the first half-hour neither side could gain the initiative, with Guy's playing well to contain a skilful Q.M.C. side. The Hospital made two chances in the first half and under normal conditions the ball would have gone into the net, but in the very heavy conditions the Guy's forwards seemed to be clogged down and this resulted in tame or wide shots. At this time the visitors realised that they had the beating of the college side and played some good constructive football. However, Q.M.C. were rather fortunate to go ahead against the run of play when Guy's centre-half misjudged a high centre, leaving it to a Q.M.C. forward on the edge of the box. He shot on the volley and the ball found the corner of the net, giving Carter no chance at all.

In the second half Guy's started with renewed vigour to reduce the deficit, but somehow the Q.M.C. team gradually became more dominant. Evans, Davey and Lovell played very well, and Carter had some good saves. In the middle of the second half the opponents' left winger was allowed to cut in to shoot well, passed Carter's outstretched hand. Q.M.C. continued play the dominant football and Guy's

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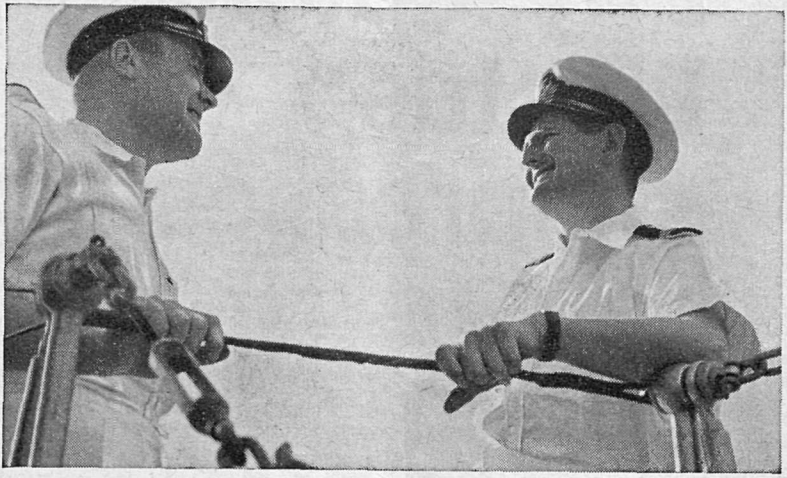

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forwards were not able to test the college goalkeeper.

Taking the match as a whole the Guy's team should be congratulated on their performance, and once again carried the tradition of hospital football well in the University competition. However, the Guy's team could note two particular points, used to effect by Q.M.C., but lacking in the Hospital's play. (i) Quick use of the ball, and not holding the ball till challenged, is most effective. (ii) Positive use of the wingers on comparative firm ground, out of the quagmire, is beneficial.

Team: M. Carter; R. Davey, P. Evans; R. Lovell, I. Nash, S. Watt-Smith; D. Jacobs, S. Poole, I. McClure, D. Lindridge, T. Dutta.

BOAT CLUB

1966 Inter-Hospitals' Boat Race

This was held at Chiswick on Saturday, 26th of November. Mr. Mansie, President of the Guy's Club, was in the Umpire's launch. This year's race is the first of a series of annual races to be rowed against our traditional rival, St. Bartholomew's Hospital, and is a revival of an old race, which was first recorded in 1840. The last result recorded in the Guy's Gazette appeared in 1926, and with this revival, forty years afterwards, we look forward to a lot more racing now that two fine trophies have been presented.

The race is divided into two divisions, one being open, essentially consisting of the Hospitals' first VIII's, rowed for May & Baker's magnificent Challenge Cup, and the other consisting of oarsmen who have not won senior events. The latter is rowed for the World Medicine Trophy, a very fine sterling silver shield.

The open race started at 3 p.m., and I looked forward to this with considerable trepidation, because Bart's have had, during the past year, one of the finest hospital crews ever. This crew has been together with hardly, if any, changes since they won the Tideway Head of the River Race last winter. A Bart's win by five, six, or more lengths would not have surprised me. From the launch, it was obvious that Bart's had gone up on the start (just above Kew Railway Bridge), but Guy's held on well. Gradually Bart's, with Guy's hanging on grimly, built up a lead of about one length, until near Ibis Boat-house the crews met some very rough water, and Guy's took a few feet back again. Unfortunately the rough water (from the wash of a barge), stopped at Chiswick Bridge and Bart's went up well to the finish at Mortlake Brewery. The Judge's verdict was one length of clear water. For Guy's this was a terrific performance, and I felt confident that they would win their race in the Winter VIII's Regatta. This they did, and we confidently look forward to developing the potential of these oarsmen next term in the Head of the River Races.

The Junior crews rowed over the same course, and were tipped to finish in the order opposite to the first division. Despite remarks by the captain of boats in the last Gazette, Guy's 2nd VIII is extremely strong, and a very promising crew, fully deserving the early lead which they took from Bart's (after a start in which they had drifted down nearly as far as the Petrol Pumps). Mistakenly, Guy's let themselves be pushed too far onto the Middlesex Station, out of the current. Despite this they maintained their lead, which was now about three-quarters of a length. The Bart's cox bored so hard that he had to be warned four times by the umpire, as a terrible sight hove into view. A flotilla of small boats was emerging from Quintin Boat-house, regardless of the race, and was moving straight across Guy's bows. Miraculously Guy's cox threaded our VIII through the mêlée, and the crew quickly regained lost ground, after Chiswick Bridge, forging on to won by two-thirds of a length. I feel that this was an unsatisfying result, which could have been improved if the crew would drop its habit of "sitting" on its rival the moment it is about half-a-length up. Nonetheless, the racing experience was invaluable, and we look to this crew for great things next term.

JONATHAN H. WILLIAMS,
Secretary, United Hospitals' Rowing Club

CROSS-COUNTRY

The club has advanced well into the season, and we ran in our first league match of the season on 22nd October. The 170 starters made the going a little heavy over a very wet 6½-mile course at Parliament Hill Fields. The standard of University cross-country, and for that matter of Guy's cross-country, can be seen by our performance in which only three of the team came higher than 108th position. Although Guy's ran with spirit, these sort of placings are barely good enough to keep us in the first division.

The next Wednesday, we went over to the London Hospital's course for a match against them and Charing-Cross Hospital. A two lap, thoroughly evil six-mile course, enabled the London to just beat us.

Brian Smith 2nd; Geoff Harrild 3rd; Dick Wilson 6th; Dave Halestrop 15th, Ed Bowen-Jones 16th.

The second league match was over the notoriously fast "round the river" course at St. Mary's College, Twickenham. This course is void of hills, and the 5½-miles of well surfaced tow-paths make the race more like a track event. The results have not yet been circulated, but Brian Smith was first home for Guy's, and was followed in by Dave Halestrop, Geoff Harrild, Dave Choat, Tony Ross and Ed Bowen-Jones.

An encouraging feature of the club is its participation in the United Hospitals' fixtures. Several of us run regularly for the United Hospitals, and have established a niche for ourselves in this, one of the oldest cros-country clubs in existence, as well as gaining the experience that senior inter-club matches provide.

R. WILSON

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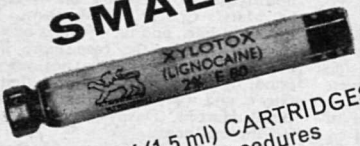

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Applications are invited for the post of **Medical Registrar,** with duties commencing as soon as possible and appointment until 30th September, 1967. Applicants should hold a Membership of one of the Royal Colleges. Forms of application are obtainable from the Superintendent, Guy's Hospital and should be returned to him not later than **22nd December, 1966.**

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Registrar in Child Psychiatry,** with duties commencing as soon as possible and appointment until 30th September 1967, in the first instance. Forms of application are obtainable from the Superintendent, Guy's Hospital, and should be lodged with him not later than **19th December, 1966.**

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The Chartered Society of Physiotherapy
Final Examinations—November, 1966

Birdsey, T. M.
Blacklaws, M. E.
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The following Nurses have passed the Final State Examination held in October, 1966:—

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Mr. and Mrs. W. J. Ferguson, Eller How, Ambleside, Westmoreland.

A. T. G. Garnett, Esq., L.D.S., Clyde House, 53, Edgar Street, Hereford.

Graham D. Hodgson, Esq., L.D.S., R.C.S., 24, Abbotifield, Tavistock, Devon.

Lionel Lees, Esq., M.B., B.S., D.(Obst.) R.C.O.G. and Mrs. Romola (née Hatch), S.R.N., 13, Barbara Close, Church Crookham, Nr. Fleet, Hants.

Dr. John R. Morrison, M.D., D. Phy. Med., Glade House, Archery Fields, Odiham, Hants. Phone Odiham 348.

Dr. K. Nicolson, M.B., Cleaveside, Queen Camel, Nr. Yeovil, Somerset.

Dr. John Payne, Laine End, North End, Ditchling, Sussex.

Mr. and Mrs. E. A. Tiller, Fair Oaks, 348, London Road, Waterlooville, Hants.

Dr. and Mrs. D. Q. Trounce, Windmill House, Great Hadham Road, Bishops Stortford, Herts.

Dr. Mark Wilks, Monkspath, Limerstone, Isle of Wight.

BIRTH

NICHOLSON—On 24th February, 1966, to Elizabeth (née Brooks) and Kenneth Nicholson, a son, John McKenzie.

MARRIAGES

HODGSON—HARDY—On 1st November, 1966, at Fleet, Hampshire, Graham D. Hodgson, L.D.S., R.C.S., to Sue Hardy.

OSBORN—LANDER—On 9th July, 1966, at Hampstead, N.W.3, Colin Osborne to Jean Mary Lander, S.R.N., M.R.I.P.H.H..

DEATH

FARRELL.—On November 26th, Dr. Rowland Henry (Ginger) Farrell, D.F.C., beloved husband of Pamela and much loved father of Roger and Nigel.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

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GUY'S HOSPITAL GAZETTE

EDITORS D. S. ROBINS and M. F. D'SOUZA

FORTNIGHTLY TWO SHILLINGS VOLUME 80 NUMBER 2046

CHRISTMAS EDITION Dec 24th, 1966

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PASSIM

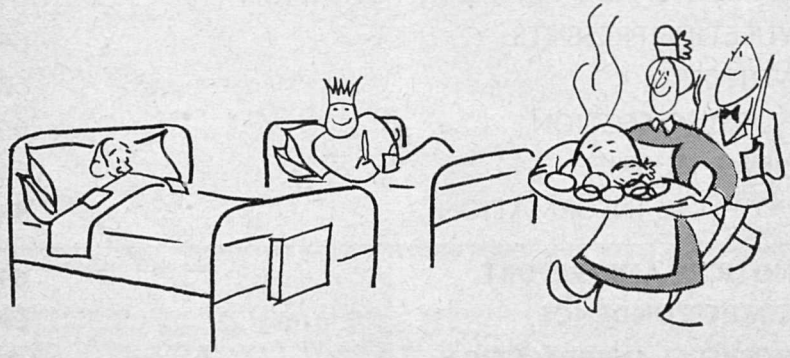
It is with deep regret that we hear of the death of Dr. Henry St. Hill Vertue who, amongst so many other things, had been a regular contributor to the "Gazette". We shall be publishing an appreciation in our next issue.

The yarn of 1966 is now almost fully woven and already the mass media have begun tying the year into a neat little knot. In an endeavour to avoid the confusion of the general Press during this festive period we ask that we may rest and be without an opinion. Instead we have pulled on the magic threads of time and drawn into present view an issue of 50 years hence. Whatever alterations may occur let us remember that standards change and what is light and possibly entertaining now may be light and possibly entertaining in the future.

For the moment Passim is, in spite of its translation, neither here nor there.

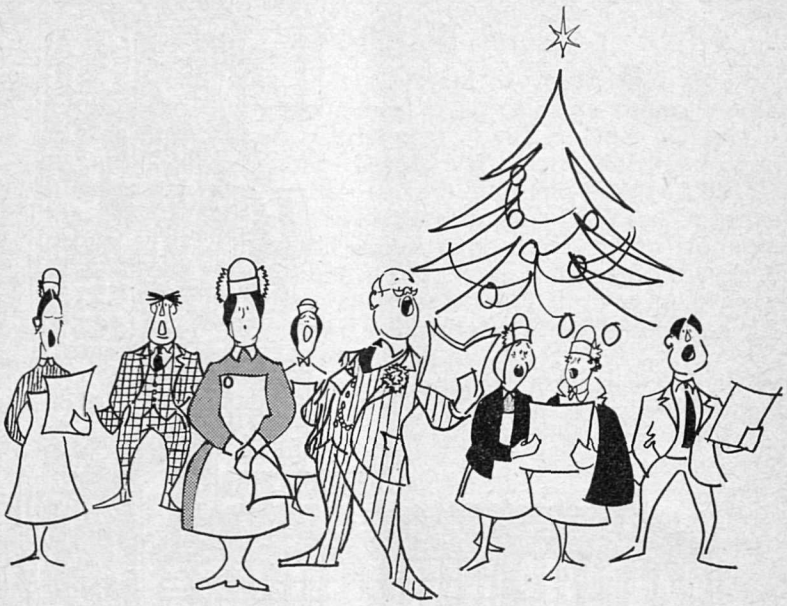
Fable?

Once upon a time a very junior nurse was asked by a staff nurse to hasten to obtain a bed-pan for a dangerously incontinent patient. On observing that the young girl maintained a sedate walking pace the staff nurse, anticipating disasters, called out to her to run. The girl, however, seemed deaf to this command, and continued about the task with as little haste as before. The mission was, fortunately, successful, but the staff nurse was understandably somewhat annoyed and asked the girl why she continued to walk when told otherwise. She was greeted with the quick and self-righteous reply that in P.T.S. they had been taught that there were only three things a nurse should run for: *Fire, haemorrhage* and *medics*. On being further questioned as to which direction she should run with regard to the medics, she blushingly replied, "Towards them, I suppose." Well, better a dirty diabetic than a lonely medic.



Soap Powder

They have now discovered enzymes. Unless we're well behind in our journal-skimming, it seems there are only hormones left now.

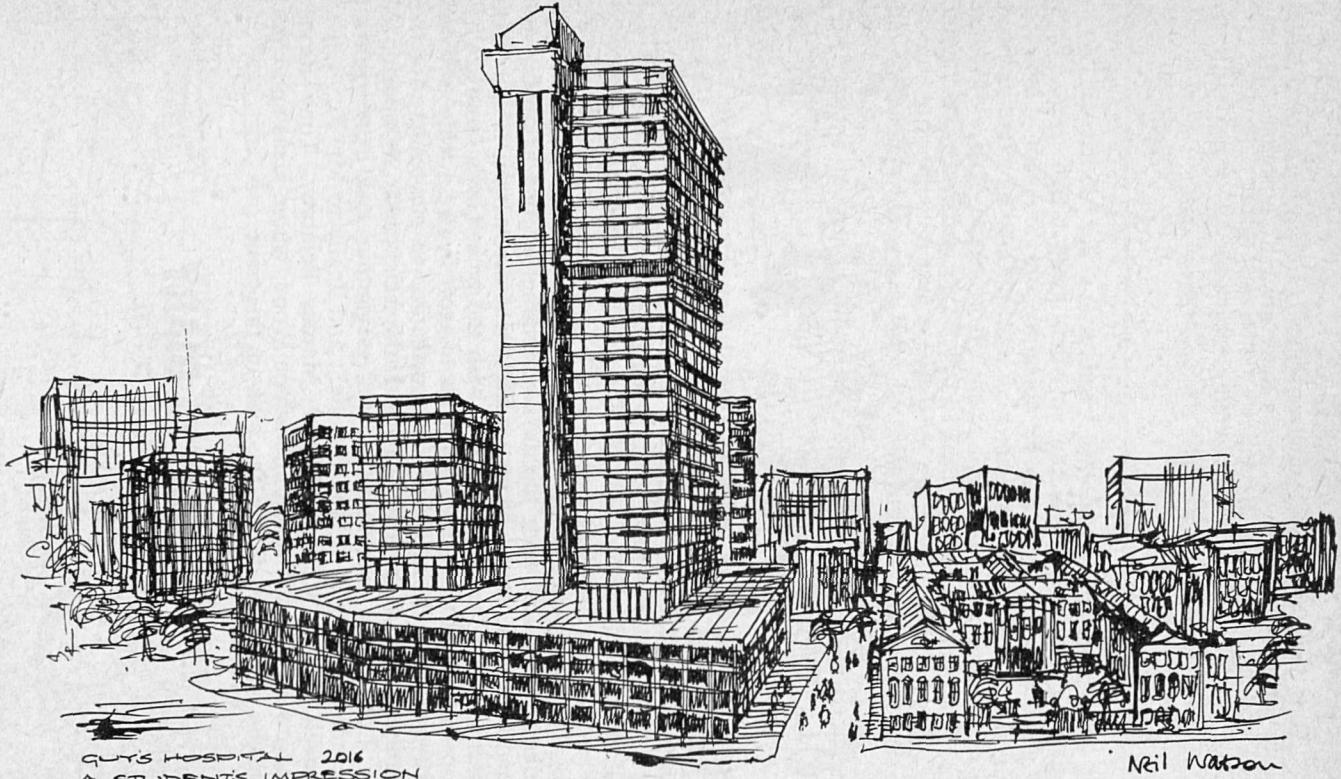


The hectic weeks are over, and at last we no longer need to strike from the calendar the days remaining before Christmas. It is upon us. As a period of rest, reflection and revelry it is still unsurpassed. It but remains for us to wish the great Guy's family, which dispersed about the world, continues to grow in size a truly enjoyable festive season. It is also a time for thanks: to our readers for their continued support, contributions and criticisms; to Mr. Warburton and Mr. Loomes for their thankless and gargantuan task in reorganizing the managerial side of the "Gazette"; and finally to Mr. Rex Lawrie, Russell Cowan, Robert Morgan, Marcus Pembrey, Tony Raynes, Andrew Seal, Neil Watson and Simon Wood, whose ideas and contributions have given life to the bulk of this issue.

GUY'S DIARY

JANUARY—Clinical Lectures

2nd	M.	1.00	Mr. BLAIKLEY. "Treatment of Carcinoma of the Cervix."
3rd	Tu.	1.00	Dr. MANN. "Chorea."
5th	Th.	1.00	Dr. HELLIWELL
6th	F.	1.00	Mr. BEARD.


GUY'S HOSPITAL 2016
A STUDENT'S IMPRESSION
Neil Watson

GUY'S HOSPITAL GAZETTE

FORTNIGHTLY 60 CENTS VOLUME 130 NUMBER 3347

PASSIM

It is perhaps with the brashness of youth that we dare produce this issue under an almost plain cover to commemorate the old-time festival of "Christmas". We do this in spite of the expected strong public disapproval of the nature ordered twenty-two years ago by the Techno Supremo when it banned all public festivities as a final part of the 28-Year Squeeze. We therefore have included above some items taken from the "Gazette" of 24th December, 1966, so as to confuse the issue, and a few items of even greater antiquity, for we have never agreed with the prophet Ford's incantation in the early part of the last century that "History is Bunk".

We would beg our readers' indulgence in seeing that the South London Press monopoly does not get hold of this copy and that they remember that most useful of mottos : "Keep it in a safe place".

Perhaps one of the most unfortunate buildings ever to be built was the College of Guy's Hospital. Not many years after its glorious and relatively flamboyant opening by Gladstone there appeared the first of what was to be a continuous protest that tested every known form of peaceful criticism. Yet the nearest it ever came to its demise was during a blitz one night in the Second World War. Protest upon protest, enfeebled however by the lack of anywhere else to accommodate students who wished to be resident at Guy's—an interesting desire—soon became established as one of the traditional topics of discussion amongst students and others. Many thought that the move of the Residents with their wall from the College to the then new quarters in the East Wing of Guy's House would be one that would mark the College's imminent razing to the ground. Even in 1965, when the "Gazette" published further plans for the rebuilding of the hospital, the College was unmistakably missing from the landscape, and miraculously the "blot" was gone. Passim, in the "Gazette" of 24th December, 1966, was obviously in possession of information secluded from the rest of the hospital at the time. It had been announced that the College was to be completely vacated in early 1967, and yet Passim failed to use the apparently last Christmas opportunity of commenting on the College. That its judgment was sound, however, was amply shown three weeks ago when the College celebrated its 39th anniversary as the Annexe to Hunt's Geriatric House and it remains a suitably ornamented edifice for the comfort of those Guy's patients who now at last in deed as before in song only fade away.

GUY'S REVISITED*

By a Retired Consultant

When I retired from Guy's I never thought that I should be revisiting the old hospital in the year 2006, and I think that an account of my findings may be of value to old Guy's men and women who are in various asyla poised in orbit, and therefore unable to pay such a visit themselves.

I had come up to the Elephant by air for the express purpose of taking my annual compulsory second-childhood-hundred-year worthiness test—a cross between the historical eleven plus and a ten-year vehicle (automobile) testing, which determines nowadays one's suitability for further replacement of worn-out parts. This, of course, has solved the problem which used to perplex us in the old days when spare-part surgery was a novelty. We could not envisage what might happen when spare parts were so readily available that people might live almost indefinitely. However, the Government solved the problem by instituting this worthiness test which is taken, of course, at the Elephant.

As a matter of fact I quite thought I had failed as the machinery murmur of my ticker had been so loud lately, and the ideaphone—I have had to use one since a recent stroke made me aphasic—got stuck and could only speak Bantu and Russian. Last time I was nearly ploughed by anaemia, since there isn't much red marrow left in my plastic bones, and I was thankful for a transfusion of plastic-coated denatured animal haemoglobin microglobules. These, of course, last indefinitely and are manufactured in quantity, and have quite replaced the barbarous practice of human blood transfusion.

While I can proudly say that I am sound in wind (oxygenator) and limb (my left arm) I still feel annoyed with the young chap who fixed me up with two right legs by mistake some years ago when my vessels became irreparable.

I flew on from the Elephant to take a look at the hospital. The front quadrangle was little changed except for a hovercar landing stage in the centre over Thomas Guy's statue, continuous with the upper deck over the courtyard for additional parking space. Most of Guy's House had been converted into quarters for the wives and families of consultants, nursing staff, etc.,

*We make no apologies for printing this account, for although written about a visit made 10 years ago, it is of historical interest, and from it can be seen just how far we have progressed since 2006. (Eds.).

and there were creches and playgroups for the younger children since the change in age distribution had made it necessary for all young people to work full-time. Hunt's House had, of course, long since been converted into a self-care geriatric unit, but I had not seen the hospital since the collapse of the Tower Block. This, fortunately, occurred at the week-end when, owing to shortage of nursing and other staff, no one was about. Its collapse, when discovered on the Monday, was greeted with some relief as it had proved so difficult to adapt and modify as circumstances changed and the demands with them. The air-conditioning had often gone wrong and led to profuse growth of the antibiotic-resistant organisms prevalent at the time. In its place there has now arisen a temporary group of low hut-ments on top of a subterranean system of screened laboratories and sterile suites in which replacement surgery is the principle type of work being undertaken.

At lunch I was told, somewhat to my surprise, that large parts of the Royal Colleges were up for sale or to let as the demand for them had fallen off to a great extent: students nowadays were apparently training in British Medical Schools, taking American qualifications and emigrating immediately to the more favourable circumstances in that country, so that the number who needed to take the qualifying exams. of the Royal Colleges had dwindled almost to vanishing point. In fact, I was informed that the shortage of doctors of all grades as well as nurses had become so serious that the patients usually flew by supersonic jets to other countries for treatment. This, though expensive, was safer in the long run than to trust one's life and health to the various doctors rejected by the Common Market and elsewhere, and who were eeking out a meagre living in Great Britain among those who failed to see the need of having their treatment elsewhere or could not afford to do so. There were, however, here and there some British-qualified doctors who had been superannuated from the old National Health Service and were still fit enough to undertake ordinary surgery and medicine in quieter parts of the country.

It has been said by some that the old-fashioned treatment was pleasanter and probably as effective as some of the more advanced methods being practised, but after this fascinating return to my old hunting grounds I do not know whether I am entirely in sympathy with this point of view.

IMMORTALITY NOW ON THE I.H.S.

From our International Health Service Correspondent

"At the Haslewood Institute for Senilofelinochemistry, Man has finally achieved his apotheosis." These were the modest, laconic words of Max Moulton, history's first reconstituted man, when Guy's Hospital announced its momentous conquest of human mortality just two weeks ago.

Moulton, twice winner of the Gent Memorial Medal and ex-sports correspondent to the Guy's Hospital "Gazette", was reluctant to say then how soon this discovery could be applied on a large scale to the general public. Now, however, it seems certain that everyone who is declared humanistically living by the end of 2017 will never have to die, and that all those who wish to be rejuvenated can be transferred to any age they choose just as soon as hospitals are built to cope with the demand.

The principles behind the techniques now used have a long history dating well back before the Third World War when it was first realised that the nucleic acids of the zygote contained the entire code for embryosynthesis. After the cruder methods of homograft organ transplants had been found to be only partially successful, embryonic organiser-hormones were used to regrow each vital organ after its diseased parts had been removed. While awaiting this period of "neoembryogenesis" all vital functions were supported or taken over by artificial means. This process became greatly enhanced when growth velocity stimulators were discovered, the so-called "Maturators" which enabled 10 years' growth to be achieved in only a month or so.

The next and major breakthrough came with the computer analysis and chemosyntheticotransference of all those chemical changes which constituted the recordings of experience in the brain and elsewhere. This led, among other things, to the now well-established Injected Memory method of teaching which is rapidly replacing our former primitive methods of education.

It was from this work that Moulton, et al, at Guy's, produced their final solution. Using the new Warwick Biocomputer, they successfully transferred Moulton's own genetic code into a readily reproducible form for resynthesis, and to this they fed the recording of idiosyncratic changes in his bioneurochemistry.

Then Moulton took the most courageous step in human history when he voluntarily submitted himself to be completely destroyed in a Hunt metabolic mincer.

——Anyone who has seen Max Moulton should laser-flash in to the Borough Police station, or videophone Whitehall 1212.

COMBINED ROUND REPORT

"A SENSITIVE PROBLEM"

The patient was accepted at 0008 Interplanetary Time into the Primary Primary Resuscitation Unit, apparently suffering from acute phlegmatic mitochondriosis, sustained in a S.T.A. (space traffic accident). The C.F.E.T. screening revealed that the patient was not a primary primary resuscitation problem, and it was referred to the Diagnostic Centre. The first impression of the patient in this unit was that there was a marked abnormality of collagen periodicity, and Prof. S. de Cameron, Kt., remarked that the patient was "off-colour". Thus the differential diagnosis at this stage lay between ribosomiasis and one of the mitochondrioses. Brain biopsy with a Warwick Ultrasonic needle produced nothing but a convulsion and it was decided to do a psychological study.

The Stafford Cerebral Clerking Test (SCCT) revealed that the patient ate biscuits in bed with its left hand and that it had a desire to sneeze in utero. It was consequently postulated that this could be an hysterical imbalance of mitochondrial activity.

A total body biopsy was not permitted by the spokesman of the patient's relatives*, but in the face of this difficulty the Chromosome Laboratory suddenly discovered a greenstick fracture (extremely rare nowadays) in the X chromosome. This was readily repaired by means of a Polani internal fixation device. A straight omegascope of the chest showed left wing tendencies—an ominous yet inexplicable sign.

At this point Prof. de Cameron felt that the patient should be referred to the "Humanist Boys" for their decision as to whether the patient was alive or dead. This laboratory reported that the patient was an artefact, and referred the case back to the Professor.

A year later an international symposium finally concluded that the patient at some time or other had coryza, a diagnosis that was, we are proud to say, in keeping with Prof. de Cameron's original observation.

*or "gene-cluster" as we should now be calling them.

RULES FOR HOUSE OFFICERS
—EXTRACTS

Each house officer will be provided with a personal secretary for all necessary clerical work. He will be expected to be able to sign his name.

House officers will not be allowed access to the wards during the daylight hours.

Thirty minutes' study leave is granted each week. House staff must arrange this time with their consultant, the librarian, the catering officer and the hospital security police. Should he not do this he will be liable to three months as a casualty officer.

Eight-roomed pent-houses with garages will be available to each house officer free of charge (in accordance with the findings of the Standing Committee of 1967). Married quarters are, of course, no longer provided.

Housemen must eat their breakfasts in bed and will not leave their rooms until they are called. They are warned not to cover the lenses of the telecommunication cameras planted in these rooms.

Housemen are to work a basic 160-hour week and to provide cover in the case of illness of one or more of their colleagues. Overtime is optional.

Clocking-in cards must be stamped each day by the Superintendent's Secretary.

House staff are reminded that the increase in salary, frozen in 1966, will materialise sometime in the near future. Incomes may be supplemented by shift work at the hospital's LSD dispensary.

Staff are asked to wear foam-covered overshoes to preserve the 20th century floors and temporary staircase in Hunt's House.

Housemen are not allowed in Matron's House without an escort and not allowed out without a medical examination.

It is the duty of all house surgeons to clean the floor of the operating theatres after each operation and the duty of all house physicians to make the beds in the morning.

Names should not be carved in the walls of the Colonnade.

The Governors wish to make clear that the recent rumour that the house staff are overworked is completely unfounded. Anyone wishing to pursue this point further is invited to see me with his bags packed.

By Order,
THE SUPER ATTENDANT.

HISTORICAL SECTION

TO CAPE HORN AND HOME

—A VOYAGE IN THE PAST

A four months' spell in New South Wales, with plenty of sport in Sydney, was a revelation to a young man brought up in the old ways in the English countryside before the Great War.

Much hospitality and kindness was shown at all levels in Australia to any young man from home. He may have had to answer searching questions about English village life with the squire and parson and tell all he knew about the little bird, the English skylark, but he did his best.

There had been much to do and see in Sydney, with its famed harbour, surfing at Manley Beach, cricket at Sydney Oval, and races in ships' lifeboats on the Parramalta River, and numberless picnics. At that time good food was cheap in Sydney and a holiday spirit seemed to pervade the whole place from the coast to the Blue Mountains. It was wonderful in the sun, indeed, it was, as no doubt it is now, one of the playgrounds of the South with perhaps the best climate in the world.

"You must sign and sail again"

Yet, when we saw the old four-masted barque, and beautiful she looked, lying quietly at anchor in Double Bay in the harbour at Sydney, loaded with wheat and wool for London, and found her ready for sea with the prospect of rounding Cape Horn, it seemed the moment had come to be gone.

On Sunday, March 12th, the cable was hove short and by 11 a.m. the tug-boat "Hero" caught hold of the hawser. Sails were loosed but not set. The ship's papers were brought on board. The anchor hove up, all boats left the ship's side, and she commenced the tow to sea.

Half an hour after Sydney Heads had been passed, at midday, the Pilot left. It was Sunday, and as the tug-boat was not wanted on harbour work and the wind light, the ship was towed about 12 miles straight out to sea.

About 3 p.m., all sail was gradually set and the tug came alongside to have his money order signed. As he turned to go back to Sydney the tug blew a cock-a-doodle-doo on his steam whistle and was heartily cheered for the assistance he had given.

A large Norwegian ship, the "Marella", bound for Falmouth for Orders, had just left Sydney that morning; she was within three miles then, at dusk was left five miles astern.

Streaks of cirrus cloud foretold a breeze, and a beautiful evening star shone brightly to the westward, while a lovely moon arose to give light. The usual watches had been set, gangs had been made up, and lookouts arranged. The routine of the ship was as well ordered as if she had not been in port. The beautiful Southern Cross, with its pointers, shone to the southward.

"Ice lookout" set

Just before sunset it began to feel very cold, probably due to an Antarctic current. In thick or hazy weather in high latitudes this makes the sailor anxious, as ice may be about. The beautiful blue colour of the water had now turned to steel grey, which made it appear colder still.

Icebergs can generally be seen a considerable distance at night and they shine out clearly in the early hours; they seem to absorb the light.

In this connection, sailors believe some men and some ships get bad luck and attract misfortune; however that may be, it is as well to keep a good look out. Captains have been known to decline a command because of the reputation of a ship.

We go well to the south round New Zealand. We passed the Suares Islands south of New Zealand. Masses of seaweed floating about.

23rd—Smell of burning in the early morning. Probably bush fires in New Zealand hundreds of miles away.

We have two Fridays

24th—In this week we have two Fridays as on this day we crossed the 180° Meridian. Sailing east the clock is put ahead. If we did not have two of the same day we should find ourselves a day ahead of the proper date on arrival in London. Sailing west, on the other hand, the clock is put back, so there are only six days in the week when the 180° Meridian is crossed.

Lunar Rainbows

Later in the evening the heavy squalls passed over the moon, showing lunar rainbows one after the other.

At midnight we made away on our course again, but little sail was set. The barometer remained low—lower than anyone on board ever remembered.

During these activities the baker could not bake bread. He produced some rock-like substance and it is regrettable to say he was pelted for his pains.

The Mutton Birds (Puffins)

On the eleventh, mutton birds were our constant companions. One Cape Pigeon seen—the first this trip. To-day there are a dozen Mother Carey's chickens. On and after the thirteenth there was not a puffin to be seen, probably driven away by Cape Pigeons. One or two "Stink Pots" or Sooty Albatrosses also attended us.

Sighted the Diego Ramirez Islands

18th—We have been having frequent squalls of rain, hail and sleet and, this morning at daybreak, sighted the Diego Ramirez Islands about 25 miles south of Cape Horn.

A very peculiar sky of a light brick-red, up to about 8° from the horizon, above which strata cumuli showing in every variety of grey colour.

The ship encounters a Pampero or Typhoon

By 7 o'clock it became very dark, the sky overcast with dense rain clouds; occasional showers of very heavy rain fell and nearly all sail was taken in. Vivid and frequent lightning showed all round the horizon. Our lightning conductors were loosened from the coils and the ends trailed in the water, with other ends at mastheads.

Practically no breath of wind, except for a few light airs soughing from one direction to another. The crash of thunder sometimes close and at others a deep note mumbling along the horizon. At about 11 p.m. it could be heard fizzing along the water and, in the calm, struck the ship in a heavy shower of hail like a gun.

Many a good ship has been lost or dismasted through not being prepared for this sort of revolving storm which is termed here a pampero, or in other parts of the world a cyclone or typhoon. Off the River Plate, these demonstrations do not last long, though heavy rain continued. But it gradually cleared and, in the morning, we were bowling along on our course at about ten knots.

It seemed to have scattered all the birds.

Owing to the heavy rolling the vessel had not made the speed she should have done. In sail, ships have to study where they are likely to get the best winds and currents so, leaving Sydney, we steered nearly south until clear of Tasmania. After that we could take advantage of the westerly winds prevailing in the higher latitudes. Again here we are steering much to the east of our direct course as when we get a little further north we may not be able to get to the eastward and may, consequently, be jammed on the Brazilian coast with wind and tide against us.

As the weather seemed more settled the First Officer had the oakum caulking removed from the cabin door, as it was handier to get food to the cabin. But, he was too previous and the door haw to be re-caulked for a few days.

On the 4th the weather was much warmer and the sea took on the dark blue of the tropics. Nearly all the sea birds left us. An occasional mollymank putting in an appearance.

Unknown Ship

Along the tumbling waste of water, afar
Beyond the steep clambering seas,
Shines in the gathering gloom of dying breeze
Of evening, a ship, or star.

A light appeared on the horizon in the evening and many observing it were convinced it was a steamer. It turned out to be the moon rising behind clouds.

It is now the rainy season on the Brazilian coast and if we had not been fortunate in getting well to the eastward we might have had deluges of rain. As we get a stiff shower now and again it is rather like a wet hothouse. Fine weather for the geraniums.

We cross the Line

The Equator was crossed about 7 a.m. on 21st. Another milestone passed on our journey. A fitting day for Divine Service. Muster in whites at noon.

Fleas have appeared again in numbers but, thank God, not so many as infected the ship in Sydney.

The crew now have a busy time, and a wet period, in these light winds with rains. It has been muggy, steamy weather for some days, heavy rain falling for hours at a time. Everyone gets a good wash. But, sails trimmed to any flow of wind—mostly light airs. Men go "below" and sleep like logs.

Shark Fishing

Mr. Procter, late Government shark catcher in Sydney, gave one of the cadets one of his special shark hooks. This was left hanging with a lump of pork on a line from the martingale to keep it clear of the ship. At about 10.30 p.m., the man on lookout passed the word along that there was a great splashing and phosphorescent flashing under the bow. Evidently something large was on the hook, so the guy line was slacked away and a shark about 7 feet long hauled alongside. A bowline was slipped over his tail and he was hoisted on board tail first and then cut up. But not before he had put up a great fight, and it was surprising how great. A foul smell was at once present around the ship, and worse in the berth which was like a greenhouse.

We are out of the Tropics

Spoke to an Italian barquentine bound from Boston to Buenos Aires, loaded with cases of kerosene.

3rd—We are to-day out of the tropics—another milestone nearer home. Flying fish flew on board. This caused some excitement among the cats. Beautiful day for Sunday. The Mate thinks this is a waste, all should be on paint-work.

Muster at noon in blue jackets and white cap covers. This delightful day for Sabbath on the seas. Divine Service in saloon.

With the trade winds the water seemed to have a dark blue transparency, rarely seen elsewhere. These winds have been good to us as we are considerably north of the summer limit laid down on charts.

We have passed the Western Islands

We passed the Western Islands—the Azores—about 13th June. A shoal of porpoises passed, sporting and jumping and swimming in fine style to the eastward. They are generally

supposed to be going in the direction from which the wind is expected but, as we have a fresh westerly wind and have made a good day's run of 174 miles, we hope that this will be the exception to the rule.

A few birds, one or two puffins and Mother Carey's chicken seen during the last two days. Through the tropics, hardly any sea birds put in an appearance. Those about are generally from the islands.

Now the weather is cooler, about 60°, most people tend to leave the deck—some playing chess in the schoolroom.

14th—The green colour of the water seems more noticeable daily and its transparency was clearly shown last evening as the porpoises were plainly visible at depth.

A few stray pieces of Sargasso weed seen.

Home

Those on deck last evening noticed a glow appearing every minute and shining round the arc of the horizon. After midnight another was seen close to it revolving in about half the time. These were the Bishops and St. Agnes Lights on the Scilly Isles. They looked as if they waved to a wanderer.

Sailing along with a good breeze, before breakfast the shores of England were first seen stretching along like a thin streak of grey cotton wool on our port bow.

By 9 a.m. the white lighthouse at the Lizard was clearly seen and shortly afterwards the two white towers of Lloyd's Signal Station. Our ensign and four distinguishing flags were shown and soon afterwards a red and white triangular flag was seen close to the towers, indicating our signal had been seen at about a distance of nine miles.

Anchors were cast off and put over the side in readiness.

As we passed within a few miles of the land the beauty of the scene must have struck the most casual seafarer. The grey-green fields of Cornwall, the white cottages of the fishermen, the little farms, and the country houses set in woods running down to the sea.

Land and Sea

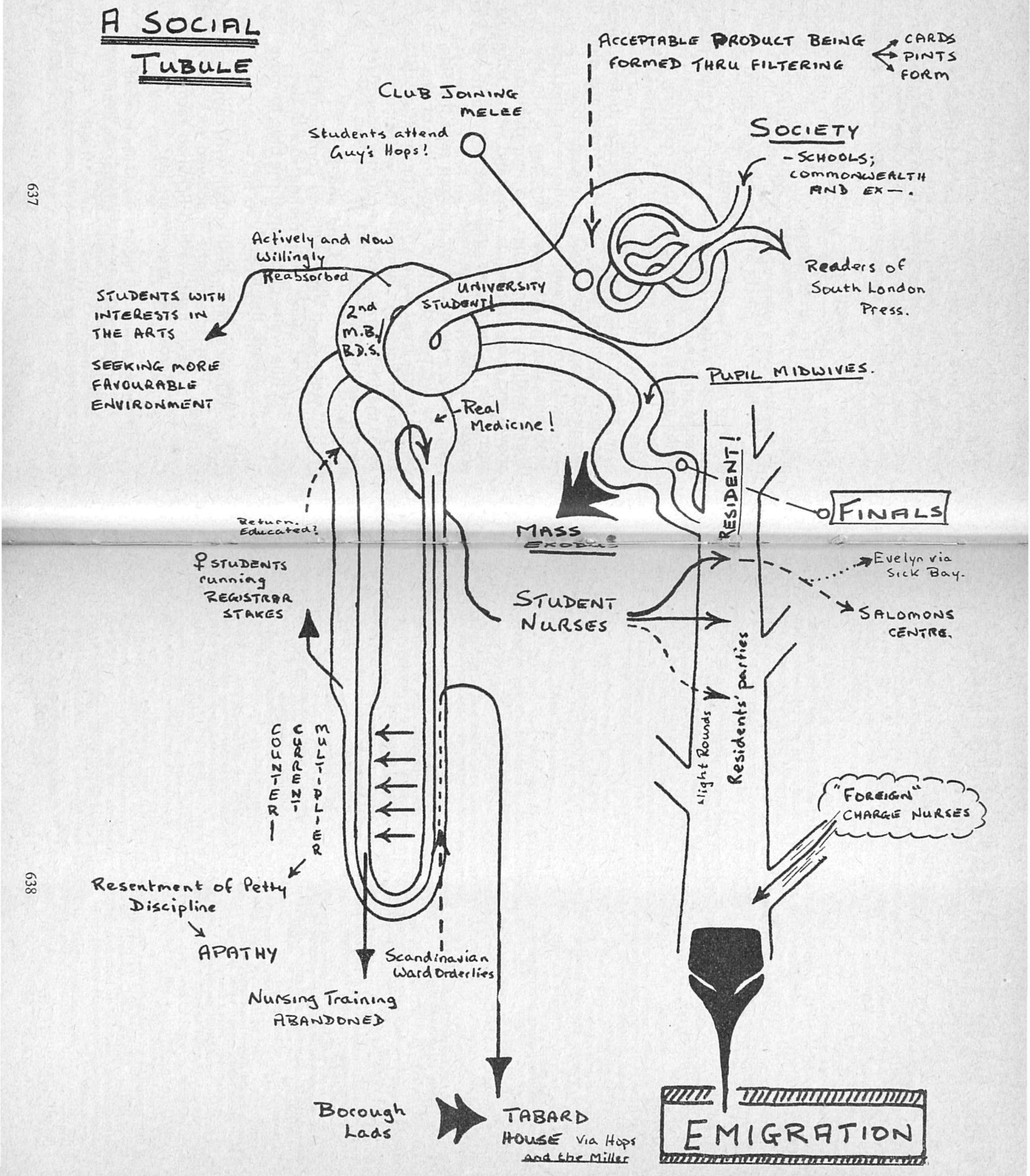
Who sends each gull and cormorant to rove
And swing their reeling roundelay;
While white clouds steal the blue to move
Above the long-flung bay?

Whence comes shrill squall, with complementary calm,
That screens the shadowed rock-shelved sea
To travis light-washed lichened farm
Across the grey-green lea?

In connection with this history I should like to record:
The Commander—Captain Maitland: A fine seaman and gentleman. Buried at Feock, County Cornwall.
The Instructor—Lieutenant Burton, R.N.R.
The First Officer and Mate—Mr. Watson: a very kindly Scotsman.

JOHN C. DOMINICK

After the demolition of the buildings that used to line the South side of St. Thomas' Broadway, and contained the old offices of the "Gazette", a few relics were gathered together and deposited with the Hospital Archivist. A recent visit made by the Editors to the archives was greeted with the following morsel. Apart from its questionably original concept it is of historic interest for its depiction of the social environment that existed among the lower echelons of the hospital community fifty years ago—or at least as it was seen by its possibly jaundiced author.



THE OLD TIME CASE HISTORY

Students in the wards of the hospital are these days so used to having Dicta-transcribed Case Histories delivered at the touch of a button, that they may find it difficult to imagine how their counterparts many years ago could spend hours with fountain pen and paper beside their patients, recording every detail laboriously so that their notes might find an unread place at the back of the sheaf of wasteful paper that used to form the record of each patient's stay in hospital.

In a period when the problem of the two cultures had not yet been solved, there was often as much discussion about the manner in which these case histories were written as there was about their content. Ninety years ago a student, irritated by his chief's remonstrations over the absence of literary style in a case history, sent the following to the "Gazette" as an answer:

Admitted for :

Post prandial pain and vomiting
Styled "something cruel".

Family History :

A tragic tale of cancer, syphilis and grisly ills
That slew first mother who did suffer much—
The rank invasion of those rebel cells
That men call carcinoma.
His father perished in a pool of blood
From ruptured aneurysm.
Of those his brothers, who still survive
The useless waste of war, one wanders
Now within the walls of lunatic asylum.
The other tills the virgin soil, hews down
The standing trees, spears leaping salmon
And careers across the wide-spread plains
In land across the sea.
His sister counts among her woes the "itch"
And chicken pox.

Previous History :

The mumps, the measles, blains and boils;
Scabies, coughs, catarrh and piles;
"Flu", flatulence and impetigo.

History of Present Condition :

Ere fell the leaves in autumn of the year
Named nineteen hundred five and twenty,
He first did notice stabbing pain that followed
After food in measured time that argues
Chemic law profound;
Two hours lapse from meal to dolorous onset
Of this agony which makes the settled food
Gush forth, blood-stained and acid.
Oft in the still cool early dawn he wakes
To pangs akin to hellish hunger.
Thus all his life is passed in dismal contemplation
Of those happy days when roasted swine,
Fresh baked beans, potato white as snow,
The crinkly cabbage, brown foaming ale
And treacle-covered batter pudding
Brought peace of mind and not a belly
Full of pain.

Condition on Admission :

A thin man, this, with alert bright eyes,
The windows of a restless mind that ever turns
The vivid, half-formed pictures of stark,
Crude distress to multiply its tortures;
And so the pain of many days has left
Its mark upon his face.
Examination of his abdomen does show
The always guarding muscle, hyperaesthesia and tenderness,
In epigastric angle, that point to lesion
Deep below—perchance in duodenum.
His acid curve ascends full high
And faecal extracts held before a fairy rainbow
Cause bands of black that tell of altered blood,
To which the blue-tinged, creamy guiaiacum
Doth add its confirmation.
A flickering light from out a crystal globe
Hath drawn a diagram of sinister distortion
In "duodenal cap".
His urine, heart, teeth, chest and tonsils
Do not protest 'gainst anaesthetic;
Nor did the ever-seeking finger find
A cancerous growth within the rectum.

The Operation :

Behold the patient!
Much purged, and painted yellow yester eve,
And wrapped this morn in cloth
Of germless white that far surpassed the mystic samite
Of that ancient King's custodian of the sword,
In magic properties all quite unknown to Merlin—
To wit, the potent charm—ASEPSIS.
And now the dripping chloroform and ether
Flow doth drown the finer sense of reason,
Till with shouts of wild and primal fear,
He beats upon restraining arms
And cries his livid condemnations
Of the world—
Then snoring breaths in measured time
Give calming reassurance.

* * *

Now parts the satin yellow skin before keen steel
And half a score of vessels spurt and flow
With blood both dark and bright
That soon is staunched with sheep gut strings
That masquerade beneath the ancient name of "cat".
In para-median line the muscle soon is split,
And guts assorted to their proper spheres
To show a pucked duodenum hard as boots
With years' old ulceration; wherefore,
With sero-serous stitch and haemostatic,
Dame Nature's path is turned a shorter way
Along posterior iso-peristaltic gastro-jejunostomy.
The breach is soon repaired by layers,
With innards filched from sheep,
And silkworms snatched from trees
And suddenly extended.
And back to bed, and neath a cradle
Filled with heat electric, he waits
The slow returning consciousness that soon is dulled
By I.M.H. of grains one-quarter.

CHRISTMAS AT GUY'S—1892

(Taken from the diary of an unknown patient)

Sunday, 25th December

Such is my lot for this Christmas, not only for myself but others also. This is a bright, fresh, healthy morning All wards, I believe, but Naaman, held Service in some way. Mr. Howse came round alone this day, not a single student with him. I have never before seen him alone. My doctor will not attend again till Tuesday.

I enjoyed my dinner more this day than any day since I have been here. I longed for an orange. I had some, but dared not touch same without asking. I asked, and was allowed one.

A visit from Mr. and Mrs. S. from Hounslow—brought me a good basket of flowers. A good long talk. I told the mystery of the Pearl Ring, and heard a few pieces of Hounslow news. So came the parting hour and off went all the visitors leaving the ward silent again. Tea came round, and a friendly chat to one another. By this time the church bells were ringing merrily, which helped to cheer us a little.

Preacher came at 7 p.m. Prayers. Preached from the 2nd chapter St. Luke. Three Hymns, Nos. 59, 60 and 297.

Pudding, nuts and oranges passed round the ward. Soon came the dark hour 8 p.m. when lights are out. Soon I fell sound asleep, so sound I did not see the House Surgeon come his usual round about 11.15. First thing I noticed was my bed letter gone. I knew well the meaning of that. Between 12 and 1 o'clock Nurse came and woke me to give me some fearful medicine. Later on comes Nurse again. Now 22 once more. "Oh! Nurse is it nasty?" "No," says Nurse. I had to take it nice or nasty. No. 3 and myself lay and whispered for some time to each other. It was at 4.20 I fell off to sleep again.

Monday, 26th December

Commenced this day by reading ten hymns and two chapters of Genesis, 15th and 16th. Washed by Nurse Holmes at 8 a.m.

8.30 a.m. I was quite comfortable, or at least as comfortable as I could be considering all things. A few songs were sung in the ward and all appeared fairly cheerful. We expect to see many strange faces today. Nurses are allowed to walk every ward this day, only two by two, to see the decorations.

Some short time back I am informed the nurses had a general strike. The hours are far too long; many of the nurses commence at 6 a.m. and finish at 8.30 p.m. making a long day. I learn they go to meals in two parties, the first commence 11.30. They have to attend Chapel several times a week. They were lately informed not to put buttons in the collecting bags. But nurses, like others, are full of fun and up to all kinds of amusements. Thanks for their kindness. The night Nurses are barred from seeing any kind of fun this day. They have to go to bed, and fancy being locked in their bedrooms! This is a usual thing, it is a rule they have to obey. Not only locked in, but no dinner this day.

This is my tenth week in bed. Eight weeks out of ten were completely lost while at Hounslow Cottage Hospital. This is the tenth, and now I can feel the wire in my knee, and pain beside the wire.

Received letters from home.

10.30 a.m. A visit from Dr. Perry, the new Superintendent. I understand the late Superintendent, I. C. Steele, was in attendance here for 39 years. The loss of him was only lately mourned.

Guy's Hospital festivities were commenced today, and will last during the whole of the present week. There are some twenty-five or twenty-six wards in the old and new wings of this great Institution, and the Christmas arrangements of so cheery and generous a nature that to many of the patients the Christmas-tide spent in this hospital will be one of the red-letter periods of their lives. Large quantities of holly, ivy and flowers have been pressed into service, while everywhere hundreds of Chinese lanterns of all sizes lend gaiety to the scene. On occasions like that of yesterday, it is the practice to allow every patient to dress who can safely be allowed to do so, and after the dinner has been served, the privilege is granted to the men to smoke, long "church-wardens" being provided. This afternoon a troupe of minstrels, "The Niggers", consisting of the students, visited a number of the wards and gave a most diverting entertainment.

I could not see the "Niggers" after they had passed my bed, we could only hear what they said—25 in number—kept the whole ward alive, not very quiet and caused plenty of laughing. When they came into the ward first one of them, a Mr. Durham, came to my bed and said to me, "I say, Governor, have some sweets". He had a tambourine full and turned a large quantity upon my bed—chocolates—mine being the first bed in the ward. Through this one stopping, the whole train was caused to stop. Soon commenced music, singing, dancing, smoking, laughing. Then came the strange faces, old faces, young faces, dear faces, dirty faces and faces never to be forgotten.

Numbers 11 and 15 kept us cheerful the whole day Monday. Ten out of eighteen beds were empty, the patients were dressed. Too busy this night to have the normal service. Two deaths in the next ward, Charity, during the night. I saw Nurse give No. 20 medicine about 2 a.m. Up to that hour we could hear Christmas Visitors on their way home.

A Child's Garden of Administration

OR

HOW TO DEAL WITH AN UNWELCOME NEW IDEA.

1. Overlook it and continue talking as if nothing had been said.
2. Change the subject.
3. Show surprise and scorn.
4. Treat it as a joke.
5. Expatiate upon its brilliance until even its author is bored with it.
6. Suggest that it is not in fact new.
7. Point out that because no one has tried it before it must be suspect.
8. Observe that it does not fit in with the generally accepted policy.
9. Mention its possible cost.
10. Remind the assembly that "we have tried it before and . . ." —very effective with newcomers.
11. Damn it with faint praise.
12. Produce plenty of reasons why it won't work.
13. Refer to the one occasion when it didn't come off.
14. Appear to accept it, then modify it out of existence.
15. Encourage doubt about its originality.
16. Associate it with Americanism, Communism, Christianity . . . or whatever movement your audience dislikes.
17. Point out all its weaknesses.
18. Make a personal attack on the author of the idea.
19. Refer to some obscure regulation which it might infringe.
20. Work it out in highly technical language.
21. Suggest that a committee examines it.

YULETIDE PRESENTS

For HIM

***** A heart-lung machine
—An exact replica of this 20th century gadget, complete with homografts, Starr valves and sterile stamping mat.
Just like father used!
Price: $5099 75c.

From: Harrods Toy Dept.

**** A 5-year supply of clinical lectures (various)—in four different colours.
Price: $10, with slides $300.

From: Foyles "Kwik-Kwalifications" Dept.
(Sent under plain cover, if requested)

* Membership of the Royal College of Physicians
—for One year: $10 50c.
—for Five years: $45.
—for Life: $100, and proof of qualification.

Apply: Playboy, Park Lane.

For HER

***** Home Plastic Surgery Kit
—Complete with: eyes, noses, ears, breasts, nipples, etc.
HIGHLY INFLAMMABLE.
Price: $1002.

From: Railway Lost Property Office

**** The Automatic Contraceptive Reminder Clock
—wakes you in the morning, makes a morning drink and automatically dissolves "the pill' on appropriate days in cycle.
A must for expectant mothers!
Price: $46 50c.

From: Fortnam and Masons Delicatessen Dept.

For CHILDREN

***** Home Doctor or Nurse Kit
—complete with a fully qualified doctor or S.R.N. and bed-pans.
Apply at you local hospital.

(An I.H.S. Free Product.)

*** A Private Burns Unit, including:
Drip stands
Fluid charts
Sterile sheets
Skin grafts
Upturned Oil Heater
Inflammable nighties
Box of matches
Instructions enclosed
Price: $206 75c.

From: R.S.P.C.C., Whitehall

** Bed Time Books For Toddlers, $2 ea.
Heart Surgery for Beginners—Earl Barry of Ross
Breasts I have Known—Plastic Clarkson
Snow White and the Seven Pituitary Tumours—The Bishop of Woolwich
I-Spy Book of Acromegalics
B.M.J. Children's Annual
Sir Jonathan Miller, as I knew him—Lady Violet Bonham Carter

NOTICES

Heart-Lung Machine

The Gordon Museum would be grateful for the acquisition of the so-called "Heart-Lung By-Pass" machine as used in the 1960's during the early days of Open Heart Surgery. This is to be shown in an exhibition entitled, "20th Century Heart Surgery—a myth or a mistake?"

News of any such machine, with or without patient, should be sent as soon as possible to Lord Pickering.

The Park

Students are requested not to use the Park for lunchtime Baseball sessions for fear of disturbing the antique artificial limbs cultivated therein. Recent such sessions have shown reprehensible disregard for the attached patients who are troubled enough by their plastic sensitivity.

NURSING SECTION

Intensu-Care

It is with interest that we look forward to the opening of this new Intensive Care Unit next month. We hear from reliable sources that so intensive will be the care that a fully-qualified nurse will be stationed in each bed twenty-four hours a day.

To ensure greater accuracy pulse rates will be taken over one hour and B.P. estimated by exposing the patient's aorta. The patient is not allowed to move, speak or breathe without being watched. Should it do so it will be asked to leave the unit.

Attached to this unit are two operating theatres, which are designed to be 100 per cent sterile by ensuring the existence of nothing therein. It is for this reason that patients are not allowed entry.

New Mattresses

This year saw the introduction of the new hover-mattresses for all three patients in the Medical block. We are pleased to note that the old automatic bed-making units and pressure-sore rubbers have now been replaced by hot-air blankets with pockets for negative-pressure bedpans. The only snag in this change is that automatic cardiac-masseur tends to bounce about and produce little effect on the dummy patients so far tested. A hospital spokesman said "Solid air fracture boards are being tried".

Transport Problems

A number of Junior Nurses appear to be having difficulties in accustoming themselves to the newly-installed Pedo-monorail system on the wards. It is a great shame that Ministry regulations continue to preclude young persons from obtaining plastic ankle anthrodeses which are of course essential for maintaining balance, for there is little doubt that pedo-monorail has drastically reduced the number of ward accidents. Matron's Office is sympathetic.

Shift System

After what has been felt to be an adequate trial run, the Shift System is to be accepted as a highly welcome and necessary administrative change.

Fashion Note

This month's fashion prize was won by E.10 wearing a stainless steel megaskirt which draped neatly just beyond the inferior point of Bryant's triangle, and a quaintly matching macroblouse which revealed outstanding ingenuity and just a glimpse of upper outer quadrant.

NEWS - in brief

An urgent enquiry has been instituted by the Board of Governors following the escape of three housemen from the East Wing to the U.S.A. A hospital spokesman commented: "We are appalled by this. It was with this eventuality in mind that we deliberately avoided extending the underground passage system to the East Wing when it was built." Evidence will be submitted to the Technology Supremo's Commission on Depopulation currently sitting on the Scilly Isles. Cabled one of the housemen: "We deeply regret pause our move."

It has been finally decided to lock the cases in the Wills Section of the Gordon Museum. It has come to the Curator's notice that some of the books have been handled over the last few weeks. In order to preserve better this monument, both the Wills and general sections of the Gordon Museum will be open only to senior members of staff, on Fridays, at 1 p.m.

Guy's won the Hospital Basketball match this year for the first time since the competition began 20 years ago. The Urn, guarded by eight hospital security police, was marched triumphantly from the ancient ground at Twickenham to the seat of the Board of Governors at the National Coal Board.

A meeting of the Board of Governors broke up in uproar last week when someone sneezed. Members of the Board will be released from quarantine in eight weeks.

The leader of the Guy's Peripatetic Unit (affectionately known as "The Boys") received the second highest number of votes in the current election of a new Minister of Comfort. A new ballot will now take place to select between the two favourites—censorship unfortunately precludes our announcing the other. Being so far in the van of progress, we received this message via our recently installed Telepathic system. As it is to be expected, the rest of the public are still unawares. Their presence, however, continues to disrupt business at the Antique Television Market at the Elephant and Castle as they remain for hours with necks craned upwards for sight of the first whiff of white smoke from the top of Alexander Fleming House that will bring the news of the election.

We are informed by a reliable source that there is talk in the corridors of the Ministry of Comfort of new moral codes for Junior House Officers. A slightly less reliable source informs us that amongst those most prominent in this talk is a former junior nurse on a ward staffed by two of the recently escaped housemen. Commented Matron's Ansafone: "I have nothing to comment."

The interiors of the new eight-roomed apartments for house officers and their families are to be designed by Lady de Cameron.

Since the uproar that recently occurred amid the ranks of the R.M.O's. of the Cleansing Department following last month's epidemic of Smog Smothering it has been decided to donate space to the unit on the top floor of the proposed Babel Block. The only difficulty left to surmount is the objection of the Universal London Council to the omission of windows.

The York clinic finally took over the last of the surgical wards in New Guy's House last week. The block is to be renamed New York House.

Officials of the Union of Theatre Orderlies and Porters (UTOP) were in an ugly mood after their claim for unemployment payments had again been turned down. They blame their redundancy on wildcat action by State Enrolled Assistant Auxiliary nurses and the archaic regulations to which they adhere. "The Laws governing theatres must be replaced," they say.

The millionth visitor to historic Hunt's House, Guy's Hospital, Mr. Andrei Svetlanov, of Baltimore, said yesterday, "I was amazed. We don't have anything like this back home."

A skeleton of an animal upon which our ancient nature correspondent pronounced the verdict, "Dachshund" was unearthed from beneath the bar in the medical school last week. Amazingly a perfectly mummified lost property list was found between the jaws.

Another attempt was made yesterday by an enraged stock-broker to drive his hovercar through the Barbara Barrier at Redhill into Inner London's public transport zone. He sustained multiple injuries and was sent to Guy's Hospital by London Bridge mono-rail, where he is still believed to be awaiting treatment by the Casualty Officer.

The tradition of giving an Aston Martin as a gratuity with the Hunt Chair in Physiology has now been stopped.

Heard during a mass meeting of the Hospital Staff, from the back of the hall, in a small voice, alone: "I read the 'Gazette'."

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Senior Registrar in Acupuncturing,** vacant from 1st January, 2017, until 30th September, 2017. Necessary requirements are a Chinese background, a mean streak and a good shot. Wet feet are a frequent hazard. Waterproofs provided. Applications to the Superintendent's Office before sunset.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Resident Thinker,** vacant from 1st January, 2017, until 31st December, 2017. The work will entail mainly straight thinking, although there is a regular clinic for dirty thoughts. The post is "on call" to the Board of Governors. Applications, with an example of one's thoughts, to the Superintendent's Office, starting the clock NOW.

GUY'S HOSPITAL, S.E.1.

Applications are invited for a **locum to the post of Senior Registrar in Visiting,** vacant from 1st March, 2017. The successful applicant will be required to visit every patient daily within normal visiting hours. Essentials for this post are fitness and a sparkling conversation. A hazard is herniation of the tongue. Videophone or write to the Superintendent's Office before the end of a conversation.

CLERKSHIPS

Applications are invited for Summer Clerkships to the Missen Mission (formerly known as the Massachusetts General), Boston, U.S.A. Applicants are reminded that they may be elligible for service in Vietnam.

PAPERS BY GUY'S MEN

The Crushed Gene Syndrome in General Practice. By Frederick Fry, M.D. *Beckenham Practitioner General,* **14**, 320.

The Pitfalls of Hope-Stimulators in the Severely Enthusiastic. By Ernest Fleminger, D.P.M., *B.J.P.*, **12**, 1672.

The value of Vacuum extraction of teeth in total exsanguination. By Lord London, F.D.S. *B.J.D.S.*, **17**, 1204.

The Control of intracellular drips. By Sir Guy Goitre, T.S.H., *B.M.J.*, **14**, 1632.

Faecal impaction in Space. By H. Wass. *B.J.S.*, 1, **16**, 45

The rise and fall of the British National Health. By A. Bevan, S.C.M. et K. Robinson, S.R.N. *Journal of the Moynahan Museum for Medical History*, 2016.

Beyond the Finger tip. By Sir Vical Smear, Bart. *B.J.Obst.*, **14**, 1963

NOTICES

Guy's Hospital Nurses' League

League members are reminded that the previously circulated Christmas Letter was published for the last time in 1964. The 1967 edition of the League Journal will be despatched in March.

The Annual Nurses' League Reunion will take place on Wednesday, 10th May, 1967, and the Biennial Cocktail Party on 21st October, 1967.

Guy's Nurses send Christmas Greetings and Good Wishes for 1967 to all League members at home and abroad.

ANNE M. JOHNSON
Honorary Secretary, Guy's Hospital Nurses' League

Dental Surgery Assistants' Badges

All those Dental Surgery Assistants who have completed the course of training at Guy's are now entitled to wear a badge, the cost of which is £1 15s. 0d. Those who wish to purchase one should write in to the Dean of Dental Studies, enclosing a cheque (made payable to Guy's Hospital Medical School) for this amount.

REPORT

Music Society Concert

Guy's Hospital Choir and the Musica Medica Orchestra presented the Guy's Music Society Concert in Southwark Cathedral, on Wednesday, December 7th, at 8 p.m. On a cold and miserable evening, there was an excellent audience that well filled the nave of this beautiful church; surely as fine a setting as one could want with its glorious architecture.

The programme offered as a major modern choral work Benjamin Britten's Ceremony of Carols (1942) and derived the rest from the eighteenth century.

The opening work was a rustic and jolly account of Vivaldi's double trumpet concerto: would that some modern composer would write such a work!

Britten wrote his work with the purity of a boys' chorus in mind. Guy's being unable to provide this more than compensated by producing some 50 ladies in the choir. I cannot praise the performance too highly. The harpist, Eleanor Bennett-Owen, was quite fantastic in her control, her variety of tone and colour, particularly the Interlude—her solo passage. She seemed to inspire the ladies to really vital singing. Their rapt concentration on the conductor, Bernard Jupp, must have been most rewarding to him. Praise here, too, for Misses Rita Lane and Judith Bennett for their beautiful singing. Most of us were thoroughly moved by this work.

If the singing in the second half never reached the same height, the performers of "Let thy hand be strengthened" and "Zaddl the Priest" were notable for the addition of the Male Voice Choir, ably led and trained by Stephen Coles—a pity that this enthusiastic group only numbered sixteen. Difficulty of balance was further accentuated by a rather over-powerful orchestra that tended to drown the choir. One irritating feature in the second anthem was the gap the conductor allowed between each section of this work, tending to break the flow and the concentration of the performers. In these anthems, Guy's provided three trumpeters: there seems at least no shortage of this breed of musician in the Hospital!

These Coronation Anthems were separated by an organ concerto, also by Handel (this event could well have happened in Handel's day). The outstanding soloist was Michael Coe, whose obvious enthusiasm for this period, coupled with a fine technique, led to an infectiously enjoyable rendering on the chamber organ: here, the orchestral support was really sensitive.

It would be a great pity if the choir was to be allowed to split up. In fact, I hear rumour to the contrary: we can look forward to a spring concert of Vivaldi and Monteverdi.

HEDLEY BERRY

The collection for Dr. Evans raised the magnificent sum of £50; a cheque for this amount will shortly be sent to Dr. Evans.

CORRESPONDENCE

The Diaspora

SIR,—Those of us whose lives are spent at Guy's may not realise the privilege we share in being Guy's men. It is only when one travels abroad and finds in the Bush in Australia, in Bangkok, on the Veld and in every part of the globe, Guy's men who will hear of your arrival, travel sometimes a hundred miles to meet you, and give a dinner party to entertain you, at which they are avid for news of what is going on in the Hospital. Their enquiries usually start with: "How's old Cony?"

My wife and I have just returned from Vancouver where we were entertained to a Guy's dinner (the first ever held there) by the following Guy's men and their wives:

P. G. Ashmore	J. M. Rigg	A. M. Marcus
D. Harris	G. Screetch	A. A. Cashmore
J. B. Parsons	J. F. Steele-Perkins	R. M. Stewart
F. N. Rigby	P. Robson	G. Stockdale

If any Guy's men are thinking of visiting British Columbia, they should contact Michael Rigg, who will undertake to look after them.

I am glad to say that all the above are healthy, happy and prosperous, and they send their collective greetings to their former colleagues.

Yours, etc.,

H. J. B. ATKINS

Department of Surgery,
Medical School,
Guy's Hospital,
London, S.E.1.

Dental Auxiliaries

SIR,—In a letter published in the "Gazette" of 26th November, Mr. L. B. Lux said that the British Dental Association "enthusiastically supported" the General Dental Council's report on dental auxiliaries. He has been misinformed. All members of the B.D.A. have received the report of the Board meeting, held on 29th October, and will have read that their representatives accepted the General Dental Council's conclusions only on the condition that standards of control and supervision of dental auxiliaries remained as stringent as they had been during the experimental scheme.

Yours, etc.,

J. N. PEACOCK

64, Wimpole Street,
London, W.1.

Secretary, British Dental Association

Shape Changing

SIR,—I must thank you for sending me the "Gazette", and send my good wishes for Christmas and the New Year.

I am still having to isolate myself for medical and family reasons, since I am subject to instantaneous shape changes, height varying between 3 ft. and 8 ft. This process is not within my control and it has a devastating effect on people who are not accustomed to it.

There are previous records of shape changers (transformation mediums), but it is a very awkward life for the recipient of the particular magic. Like Alice in Wonderand, I probably ate something. Verification of this manifestation can be obtained from my present medical attendant, Dr. Prosser, The Surgery, Aylsham Road, North Walsham, Norfolk. The only reason I am

disclosing this information is that my shape changes are being too well known locally in this sparsely populated area. I am not available for diagnosis or treatment or exhibition, but hope to keep this non-acceptable form of supernatural power concealed from the general public as long as is possible. My last visit to Guy's was about four years ago, to the Dental Department, where I was the subject of a students' teaching by Mr. McDonald.

Since I have too many personal problems to solve to undergo any form of dental treatment, I am still in possession of the same number of carious teeth as I was when I saw Mr. McDonald (you might let him know the reason for my avoiding surgery). I do not remember any previous records of shape changing in modern times. You might investigate.

Yours, etc.,

JAMES G. DOUGLAS, L.D.S., R.C.S.(Eng.) 1928

Manor Cottage,
Mill Road,
Banningham,
Aylsham, Norfolk.

Refresher Courses for General Practitioners

SIR,—I recently attended an excellent and stimulating session at Guy's of two days General Medicine, followed by three days Psychiatry. Both subjects, needless to say, were presented very suitably for rusty G.Ps., and everyone attending seemed to enjoy themselves thoroughly, particularly the old Guy's men.

Surely, sir, this sort of postgraduate teaching should be extended at Guy's. I appreciate that a lot of extra work falls on busy consultant staff and suggest that much of the organisation and teaching could be done by the registrars here, with payment for same by the Ministry of Health. The latter now recognises the desirability for such courses and surely could be prevailed upon to pay for longer and more extensive courses at the premier teaching hospital?

The demand to attend such courses exists, I am sure, for applications far exceed vacancies for those held.

Cramond House,
Sandwich,
Kent.

Yours, etc.,

J. R. GREAVES

Art Exhibitions

SIR,—It was with much surprise that I read Margot Cameron's comments on B. A. Wooster's sculpture, which she reviewed in "Winter Art Exhibition" ("Gazette" 10.12.66). Personally, and I am aware that this is a personal opinion, I view this form of modern art as a complete humbug, pleasing neither visually, nor aesthetically. As an experiment with materials, I agree it is worthy of remark, but surely not the praise Mrs. Cameron has given it? This form of art could equally well be mass produced. It's very angularity suggests a machine-made object. Would a set of plough shears be so highly praised?

This is, as I have stated, a personal opinion, and I expect that my remarks will be contradicted by the "with it" public, and that Mr. Wooster will continue to have much success with his sculpture.

Yours, etc.,

KEITH STEWART

159, Henley Road,
Ipswich,
Suffolk.

Ginger Farrell

SIR,—I should be grateful if you could find room for the enclosed in the next issue of the "Gazette". I am quite sure that so many of Ginger Farrell's old friends abroad and at home would so much enjoy reading the Address which was given at his memorial service by the Reverend W. D. Marsden-Jones, Vicar of Copthorne, Sussex.

Yours, etc.,

J. GOODLIFFE

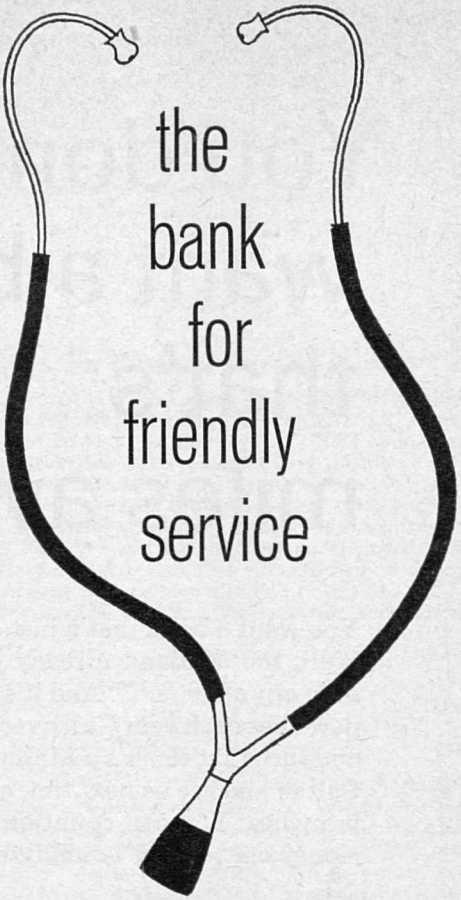
Guy's Hospital Medical School.

You don't want a bank that's miles away

You want a bank that's just around the corner. Well, the Midland already has *more branches than any other bank.* And it's building dozens of new ones each year—all over the country. So the odds are that there's a Midland close to *you.* Call in and see us next time you pass one of our branches. You can count on our help with any money matter you would like to discuss.

Midland Bank

THE BANK THAT KEEPS AHEAD—ON YOUR ACCOUNT



National Provincial

The Guy's Hospital Office, which is opened for your especial use, is under the management of Mr. A. C. Edwards, Southwark Branch, 10-14, Southwark Street, London, S.E.1, and enquiries will be welcomed.

We are here today to honour the memory of a man who was known by many different names. To some he was, of course, Dr. Farrell. To others he was Roy. To others again he was Rowland. But I fancy that to most of us here he was, affectionately, Ginger.

But however different the names by which we knew him, it was the same person we knew, and who drew out of us all that same blend of affection and admiration.

There are many aspects of the life of this remarkable man of which I am not competent to speak—as war-time pilot, medical student, doctor in general practice, broadcaster—of these and other times and aspects of his life there are here today those who could speak from their own knowledge and experience. (Incidentally, I wonder if it would not be a very worth-while thing if a symposium came to be written by some of the people who knew him at different times and in different ways. I leave the idea with you.)

Today I can speak only of the man I knew, indeed, whom I counted it a privilege to know. And as I never knew him except through "Heatherley", I never knew him except as a man increasingly crippled by a mysterious and terrible disease which is an outrage and an affront to our humanity. But this was borne by Ginger with a quiet dignity which humbled as it inspired those who beheld it. Outwardly ravaged in body, but within there burned a triumphant flame which, though once descending into the dark vale of doubt and despair, was never extinguished, and came to glow with a noble and serene brightness which warmed and encouraged all who came within its radiance.

When pains and afflictions come to human kind as they do; when we can see no point nor purpose in life; when we see only what appears to be waste and frustration; when we can find no satisfactory intellectual answer to what is called the problem of pain; it is then we need the Ginger Farrells of this world, who although not able to give the solution to the problem (it is insoluble this side of the grave) show us how it may be met—and this surely is what really matters?

In the fires of tribulation through which Ginger passed, there was forged a faith which led him to accept his heavy cross and to offer it to Almighty God in and through the offering of Christ in Calvary, for all mankind.

It was this which kept alive his great sense of fun, his intense and abiding interest in all life, his deep concern for others, for the family at "Heatherley" as for his own beloved wife and children. It was this which kept secure his inward peace.

One day we shall know, you and I, how much we and our fellow men owe to him and those like him. And when we, whose lives are the richer for having known Ginger Farrell, speak of him in days to come, this should surely be accounted his greatest work, and his most enduring memorial.

Finally, here is a quotation. I am sure you will agree these words were never more fittingly applied.

> "Then said he, I am going to my father; and though with great difficulty I am got thither, yet now I do not repent me of all the trouble I have been to arrive where I am. My Sword I give to him that shall succeed me in my pilgrimage; and my Courage and Skill to him that can get it. My marks and scars I carry with me, to be a witness for me, that I have fought his battles who now will be my Rewarder.
>
> "When the day that he must go hence was come , many accompanied him to the riverside, into which, as he went, he said, Death where is thy sting? And as he went down deeper he said, Grave where is thy victory?
>
> "And so he passed over, and all the trumpets sounded for him on the other side."

"The Pilgrim's Progress"
John Bunyan

HOSPITAL INFORMATION

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the post of **Pre-Clinical Tutor,** with duties commencing 1st February, 1967, and appointment until 30th September, 1967, in the first instance. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be forwarded to him not later than **31st December, 1966.**

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of **Senior Lecturer/Lecturer (full-time)** in the **Department of Dental Medicine,** with duties commencing as soon as possible. Salary according to qualifications, age and experience in the following ranges: Senior Lecturer—£2,315 to £3,085; Lecturer—£1,580 to £2,535, both with superannuation. Forms are obtainable from, and should be lodged with, the Dean, Guy's Hospital Dental School, London, S.E.1, not later than **Saturday, 14th January, 1967.**

SCHOLARSHIPS

GUY'S HOSPITAL DENTAL SCHOOL
TRAVELLING SCHOLARSHIPS

Attention is drawn to the undermentioned Travelling Scholarships which are now available:

Newland-Pedley Travelling Scholarship

This Scholarship will be awarded to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to undertake a year's postgraduate dental study at an institution abroad approved by the Dental Council. The value of the Scholarship will be up to £1,000 and the actual amount of the award will depend upon whether the holder of the Scholarship proposes to spend a year at an institute in Europe or Scandinavia or whether the year will be spent in Canada or the United States. The holder of the Scholarship may be required to undertake teaching duties in this School for the academic year following that in which the Scholarship is held.

Dental Travelling Scholarship

This Scholarship has a value of £250 and is awarded every third year to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to study at one or more Dental Schools abroad which are approved by the Dental Council.

Both these Scholarships will be offered for award in 1967. *In order that applications for* the Travelling Scholarships may be considered by the Dental Council in sufficient time to enable the successful candidates to make arrangements for travel, etc., it is necessary for all applications for Travelling Scholarship for 1967 to be received by the Dean of Dental Studies by **1st February, 1967.**

The Dean of Dental Studies will be pleased to discuss the matter with anybody who is interested.

PERSONAL

ASSOCIATE/ASSISTANT. Excellent opportunities in modern dental practice in the City. View to partnership for the candidate. Contact TER 8727.

THE BIRDHURST NURSING HOME is now under new management; fees from 12 gns. weekly. Phone Matron, CRO 2277.

MODERN Private Dental Practice, West Surrey, with own laboratory. Experienced, married Guy's man wanted to join with a view to partnership. White Box No. 66/24/12, giving particulars of past experience and brief personal details.

CHANGES OF ADDRESS

Mr. R. C. L. Feneley, 105, Reedley Road, Stoke Bishop, Bristol 9.

Dr. and Mrs. T. Roe, Apartment 7, 160, Bertrand Avenue, St. Boniface 6, Manitoba.

Ievan Li Thomas, Esq., B.D.S., P.O. Box 1718, Melfort, Sask, Canada.

BIRTH

BLACKWELL.—On 7th March, 1965, in Umm Said, Qatar, to June (née Selby-Adams) and Harry, a son, Alfred Selby Ricardo, and on 22nd July, 1966, in Cornwall, a second son, Edward Jeremy.

MARRIAGE

ROE—McCORD.—On 7th November, 1966, at Holy Trinity Church, Winnipeg, Timothy Roe to Susan Eileen McCord, S.R.N.

DEATHS

ARBUTHNOT LANE.—On December 2nd, at Lyme Regis, Jane, aged 82, wife of the late Sir W. Arbuthnot Lane, Bart. and sister of Nathan and Clement Mutch.

FORSYTH.—Mrs. Annie Lucy, on December 5th, at home. Beloved mother of Jean and Margaret, 7, Norman House, Riley Road, London, S.E.1.

ROE.—During November, in Australia, Mr. Arthur Stanley Roe, aged 81.

VERTUE.—On December 11th, suddenly, at Orpington Hospital, Dr. Henry St. Hill Vertue, M.A., D.M., aged 75 years, late medical officer, Salomen's Centre.

We would like to remind our readers that all copy for inclusion in the Gazette must be received eight days before the publication date.

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